

Evelyn Page Retirement Village Limited

Current Status: 3 December 2013

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

General overview

Evelyn Page Retirement Village is owned by Ryman Healthcare. The service has capacity for up to 137 residents including 20 certified serviced apartments. On the day of the audit there were 126 residents: 38 residents receiving rest home level care including 11 in serviced apartments, 53 residents receiving hospital level care and 35 residents across the two secure dementia units. The village manager and clinical manager has maintained at least eight hours annually of professional development activities related to management.

The service has in place a village manager that commenced in July 2011 after relocated as village manager from another Ryman facility. He is supported by an experienced aged care clinical manager. Families, residents and the general practitioner interviewed spoke very positively of the care provided. Staff turnover is low. The service had a sentinel event and is currently waiting on the coroner's outcome.

This audit has identified improvements required around restraint documentation, challenging behaviour documentation and medication fridge temperatures.

Audit Summary as at 3 December 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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 3 December 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 3 December 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 3 December 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 3 December 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 3 December 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Infection Prevention and Control as at 3 December 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Audit Results as at 3 December 2013

Consumer Rights

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

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

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

Organisational Management

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

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

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

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

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

Continuum of Service Delivery

A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and that the admission agreement is discussed with them. The registered nurses are responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, 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 specific interventions for challenging behaviours are documented in the behaviour nursing care plans. Resident files are integrated and include notes by the GP and allied health professionals. The GP completes three monthly resident reviews.

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. Community links are maintained. There is regular entertainment and outings.

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 and special instructions for administration. The GP reviews the medication chart three monthly. There are improvements required to ensure the medication fridge temperature is maintained at an acceptable range.

Food services and all meals are provided on site and transported to each dining area for serving. Resident's individual food preferences, likes and dislikes are known. Alternative choices are offered. There are nutritional snacks available 24 hours in the special care units. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene.

Safe and Appropriate Environment

The facility is purpose built. All building and plant have been built to comply with legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. All rooms have en-suites. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. The lounge areas in each wing are spacious.

Activities can occur in any of the lounges. Furniture is arranged to ensure residents are able to move freely and safely in all units.

The organisation provides housekeeping and laundry policies and procedures, which are robust and ensure all cleaning and laundry services are maintained and functional at all times. Chemicals are stored safely throughout the facility.

The gardens and grounds are well maintained and can be accessed safely. The special care unit has safe secure outside access and spacious internal walking pathways.

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

Restraint Minimisation and Safe Practice

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

There are eight bedrails identified as enablers and 17 restraints used in the service.

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

Infection Prevention and Control

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

The infection control policies are comprehensive and reflect best practice.

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

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

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

HealthCERT Aged Residential Care Audit Report (version 3.91)

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:	Evelyn Page Retirement Village Limited		
Certificate name:	Evelyn Page Retirement Village		
Designated Auditing Agency:	HDANZ		
Types of audit:	Certification		
Premises audited:	Evelyn Page Retirement Village, 30 Ambassador Glade, Orewa,		
Services audited:	Rest Home, Hospital – geriatric/medical and dementia		
Dates of audit:	Start date: 3 December 2013	End date: 4 December 2013	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			126

Audit Team

Lead Auditor	XXXXX	Hours on site	17	Hours off site	7
Other Auditors	XXXXX	Total hours on site	17	Total hours off site	6
Technical Experts	XXXXX	Total hours on site	12	Total hours off site	3
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	46	Total audit hours off site	18	Total audit hours	64
Number of residents interviewed	11	Number of staff interviewed	27	Number of managers interviewed	4
Number of residents' records reviewed	12	Number of staff records reviewed	13	Total number of managers (headcount)	4
Number of medication records reviewed	24	Total number of staff (headcount)	167	Number of relatives interviewed	6
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:

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

Dated Wednesday, 22 January 2014

Executive Summary of Audit

General Overview

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The service has in place a village manager that commenced in July 2011 after relocated as village manager from another Ryman facility. He is supported by an experienced aged care clinical manager. Families, residents and the general practitioner interviewed spoke very positively of the care provided. Staff turnover is low. The service had a sentinel event and is currently waiting on the coroner's outcome.

This audit has identified improvements required around restraint documentation, challenging behaviour documentation and medication fridge temperatures.

Outcome 1.1: Consumer Rights

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

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On-going staff development through education and in-service training is strongly supported and this enhances the quality and risk management programme.

Training and the delivery of service, supports evidenced-based practice. The complaints processes are implemented and complaints and concerns are actively managed.

Outcome 1.2: Organisational Management

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

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

seven days a week and staffing levels meets contractual requirements.

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

Outcome 1.3: Continuum of Service Delivery

A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed the admission process and that the admission agreement is discussed with them. The registered nurses are responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, 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 specific interventions for challenging behaviours are documented in the behaviour nursing care plans. Resident files are integrated and include notes by the GP and allied health professionals. The GP completes three monthly resident reviews.

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Outcome 1.4: Safe and Appropriate Environment

The facility is purpose built. All building and plant have been built to comply with legislation. There is a maintenance person and preventative maintenance programme including equipment and electrical checks. All rooms have en-suites. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. The lounge areas in each wing are spacious.

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The gardens and grounds are well maintained and can be accessed safely. The special care unit has safe secure outside access and spacious internal walking pathways.

Regular fire drills are completed. Emergencies and first aid are included in the training programme. There is a civil defence kit for the whole facility. Call

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	i)Two of two special care unit resident nursing behaviour charts do not specify alternative strategies/activities for de-escalation of behaviours. ii) Two of two special care unit resident behaviour monitoring charts record "re-direct" to de-escalate behaviour. iii) Two hospital residents' behaviour monitoring charts record the administration of haloperidol for "restless" behaviour. The use of prn medication does not align with the medication signing sheet, progress notes and behaviour monitoring chart.	i)Ensure behavioural nursing care plans include specific alternative strategies and activities that cover a 24 hour period for the de-escalation of disturbing behaviour. ii) Ensure specific alternative strategies to de-escalate disturbing behaviour is recorded on behaviour monitoring charts used. iii) Ensure alternative strategies are documented on the behaviour monitoring as attempted to de-escalated behaviour before the use of prn medication	60
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 Low			
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	PA Low	There is no corrective action taken for the hospital medication fridge temperatures consistently outside of the acceptable range.	Ensure corrective action is taken to maintain the medication fridge temperature within the acceptable range.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		medicine reconciliation in order to comply with legislation, protocols, and guidelines.				
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.3.2	<p>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:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	PA Low	Two restraint files were reviewed for residents with three identified forms of restraint. (bedrail, lazyboy and table). The care plans did not identify the three forms of restraint or interventions to manage. The restraint monitoring form (while completed) did not identify which form of restraint was in place.	Ensure care plans reflect interventions to manage assessed restraints. Ensure monitoring forms reflect which restraint is in place.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Attainment and Risk: FA
Evidence: Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the Code. Staff receive training for rights at induction and on-going, this is also covered in the staff questionnaires completed throughout the year. Discussions with 10 caregivers (three rest homes, three hospitals, three dementia, one serviced apartments) show an understanding of the key principles for the Code of Consumer Rights in providing services. Eleven residents interviewed (five hospital and six rest home) and six family (three hospital, two dementia, one rest home) interviewed stated that their rights are upheld and staff treat them with respect and give dignity to them

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.

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

There is a welcome information booklet/folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family and, as appropriate, their legal representative. On-going opportunities occur via regular contact with family to discuss any issues as they arise. This is also reinforced through two monthly resident meetings in each area and six monthly relative meetings (each area). Advocacy pamphlets are clearly displayed on the noticeboard on each floor. Advocacy is brought to the attention of residents and families at admission and via the two monthly resident meetings, six monthly relatives meetings and the information pack. Interviews with eleven residents all confirm that information has been provided around advocacy. D6, 2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and Health and Disability Commission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>The facility provides physical, visual, auditory and personal privacy for residents. Each resident has their own room and ensuite. During the visit, staff demonstrated gaining permission prior to entering resident private areas. Ten caregivers interviewed (across each area) described ensuring privacy including knocking before entering. The call bell system also identifies when a resident is providing cares in a resident room. Advised this ensures staff are not entering a number of resident rooms in search of staff for assistance.</p> <p>The service has a policy in place that includes that personal belongings are not used as communal property. Values and beliefs information and resident preferences are gathered on admission with family involvement and are integrated with the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with 10 caregivers identified how they get to know resident values, beliefs and cultural differences.</p> <p>Interviews with eleven residents confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with 10 caregivers describe providing choice, including what to wear, food choices, what time they want to get up, activities and whether they want to be involved in activities.</p> <p>The clinical manager described 'aging in place' and assisting residents to stay in their serviced apartment with increased support when residents assessed as requiring rest home level.</p> <p>There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect training was last delivered in July 2013 (23 attended). There are competency questionnaires included as part of induction. Staff competency questionnaires are also completed as part of the RAP programme, these include questions around abuse and neglect and are completed annually by staff. Discussions with 11 residents and six family members interviewed were all positive about the care provided.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.</p> <p>E4.1a: Two of two dementia families interviewed stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment. Memory boxes are on the bedroom doors.</p>

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.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff receive cultural safety training (last August 2013). Cultural needs and support is identified in care plans. There are no residents that currently identify as Maori.</p> <p>There is an established Maori Health plan and individual care plans include the cultural needs of residents.</p> <p>A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e).</p> <p>D20.1i The service has an established a local contact who is Māori and is available for advice as required.</p> <p>The policies for Māori identify the importance of whānau and 10 caregivers and three registered nurses interviewed including the clinical manager discussed the importance of family involvement.</p> <p>Discussion with seven family members confirms that they are regularly involved.</p>

Interviews with the clinical manager, hospital and dementia unit managers, three registered nurses, serviced apartment coordinator, and 10 caregivers confirms that they understand support for residents identifying cultural needs

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

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

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

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

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

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

Criterion 1.1.4.5 (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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into the 12 resident care plans (four hospital, four rest home [including one from serviced apartments], four dementia).</p> <p>D3.1g The service provides a culturally appropriate service by asking residents and family members what their cultural needs are at each assessment and including any needs in the plan and review.</p> <p>D4.1c During the admission process, a registered nurse or clinical manager along with the resident and family whenever possible complete the documentation and this includes recognition of the resident culture, values and beliefs. Interviews with 11 family and six rest home residents and five hospital residents confirmed that values and beliefs are considered.</p>

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

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

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

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

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

ARHSS D16.5e

Attainment and Risk: FA
Evidence: Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. The serviced apartment coordinator, three registered nurses (one hospital, one rest home, one dementia) interviewed are able to describe appropriate boundaries between staff and residents and their families. Eleven residents interviewed (five hospital, six rest home) and six family interviewed did not identify any incidents related to discrimination and confirmed they were very happy with the care provided. Staff have had training on the professional boundaries June 2013 (87 attended sessions across various times. The RNs have also completed the new code of conduct (NZ nursing council) as part of Journal Club 2013.

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

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

Attainment and Risk: FA
Evidence:

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a thorough and individualised Ryman Accreditation Programme (RAP). This programme includes using some indicators from the standard on safe indicators in aged care and for rest homes/hospitals/dementia for falls rate and urinary tract infections targets. Care planning is holistic and integrated. There is a strong commitment to staff development by way of education and in-service training. Management at Evelyn Page hold repeat training sessions and tool box talks to ensure a large number of staff attend.</p> <p>A2.2 Services are provided at Evelyn Page that adhere to the health and disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.</p> <p>D1.3 All approved service standards are adhered to.</p> <p>The service continues with yearly surveys of residents and relatives to determine key areas of quality of life, quality of care and quality of service and develop quality improvement plans to address issues and link to objectives for subsequent year. Food service, laundry and complaints management were identified as areas requiring improvement in the satisfaction survey last year and Quality Improvement Plans were developed and evaluated in response (QIPs).</p> <p>The service has objectives that have been reviewed and documentation of the review reflects best and evidence based practice. Examples of changes that have continued or are being implemented in 2013 include the following (but not limited to): (i) participation in the ACC vitamin D initiative to reduce falls in the elderly. (ii) A Back Care Champion assists with induction of new staff regarding manual handling. Also annual training for all staff in back care. Ryman Healthcare introduced the role of Physio Assistant and Back Care Champion in all their Villages. Evelyn Page identified someone into the role and she works closely with the physiotherapist in improving and maintaining the mobility of residents. (iii) Incident report and infection report analysis – review for trends and patterns occurs monthly and QIPs were developed in July when falls had increased. Progress and interventions/evaluations continue with feedback and discussion in meetings. October identified a decrease in falls. (iv) as a focus on service delivery for all residents including primary care nursing teams and documentation, further training/tool box talks have been provided to RNs and a senior caregivers meeting has been established to address clinical issues.</p> <p>Eleven residents interviewed (five hospital, six rest home) and six family interviewed spoke positively about the care and support. The service uses a</p>

resident-centred and the participation based model of care for residents. The management team described how these models ensure that staff liaise with the resident for the best outcome.

The management team including the village manager, assistant manager and clinical manager are looking at ways to improve resident's lives through the quality and risk management programme and through a team approach to management and leadership. Discussions individually with the clinical manager, village manager, assistant manager indicate that there is a strong team approach with each having defined areas of responsibility. There is evidence of robust discussion of issues through the weekly management meetings and through the Ryman Accreditation (RAP) meetings.

There is a nurse journal club. Nurses review articles/research and questions provided by head office. The planning of residents care includes input from residents, relatives, caregivers, nurses, allied health professionals and GP's. All 12 residents files reviewed provided evidence of multidisciplinary care. Care planning is holistic and integrated with policies and procedures. The education programme provided to staff includes evaluation of sessions and competency assessments. All staff have been required to complete foundations training within a timeframe. Monthly reports from head office provide feedback on timeframes.

Registered nurses complete a 'duty leadership' learning package. Ryman also have a management development programme which includes a Ryman learning tool. The service completes regular weight management audits to ensure weights and nutritional status of residents is monitored closely. A Dietitian is involved at least weekly at Evelyn Page. A 'falls response' is completed around falls and this is further analysed to consider ways to minimise the potential for further falls. Ryman completes an announced internal spot audit six monthly at each site that focuses on clinical management and documentation. This was recently completed at Evelyn Page with a 92% overall result. QIPs have been actioned as a result of that spot audit. Specific training around dementia care and managing behaviours including de-escalation skills is provided to staff at least annually.

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.

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

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

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

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

Attainment and Risk: FA

Evidence:

Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise.

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

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

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

D11.3 The information pack is available in large print and advised that this can be read to residents.

Policies and training support staff in providing care and support so that residents can make choices and be involved in the service.

Interviews with 10 caregivers interviewed (across all three areas) identify that consents are sought in the delivery of personal cares and this is confirmed through interview with four hospital and six rest home residents.

Incident forms reviewed (17 across all three areas) indicate that family are informed following an incident.

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

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Policies and training support staff in providing care and support so that residents can make choices and be involved in the service. There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interviews with 10 caregivers (three hospital, three rest home, three dementia and one from serviced apartments), identify that consents are sought in the delivery of personal cares and this is confirmed by 14 residents (nine from the rest home, three from the hospital and two from serviced apartments). Written consent includes the signed admission agreements and medical care guidance plan and care plans acknowledgement document. All 12 resident files; four rest home (including one resident in the serviced apartment), four hospital and four dementia residents (included one respite) files reviewed has signed consent forms. Advanced directives / resuscitation policy is implemented in all 12 resident files reviewed. Resuscitation forms are reviewed annually.</p> <p>D13.1 t There were 12 admission agreements sighted and all had been signed.</p> <p>D3.1.d Discussion with six family (three from the hospital, one from the rest home and two from the dementia unit) identified that the service actively involves them in decisions that affect their relatives lives</p>

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

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

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

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.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file as confirmed by the residents and family interviewed. D4.1d; Discussion with six of six family identified that the service provides opportunities for the family/EPOA to be involved in decisions. ARC D4.1e: The resident file includes information on residents family/whanau and chosen social networks as sighted in all 12 files reviewed. The complaints folder indicates that complainants are informed that they can access advocacy services to support them if needed

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations.

D3.1: Interviews with six families indicates that they are encouraged to be involved with the service and care including being informed of care planning reviews with an invitation to participate.

D3.1.e: Discussion with staff and relatives indicates that they are supported and encouraged to remain involved in the community and external groups such as church, bowls, shopping, events in the community, library.

Visiting in the service can occur at any reasonable time. Interviews with 14 residents, seven relatives confirm visitors are welcome, are included in discussions and asked if they would like a cup of tea and visitors were sighted coming and going on the days of the audit and engaging in activities with the resident.

There are two forms in each resident file: a) a contact form re who to contact in the event of an incident with differing levels of incidents review; b) a care plan acknowledgement document, which is signed by the resident or family. These are completed in all 12 files reviewed (four hospital, four rest home and four dementia).

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>D13.3h. The service has in place complaint management policies and procedures that are aligned with Code 10 of the Code of Rights. A complaints register/folder is in place that documents complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau as stated by 11 residents interviewed (five hospital, six rest home) and six family interviewed including three hospital, one rest home and two dementia.</p> <p>The entry pack includes a summary of the complaints procedure.</p> <p>The complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. A separate register is maintained for the rest home and the hospital.</p> <p>Complaints are documented on VCare.</p> <p>Complaints and verbal complaints reviewed for 2013; five written and one verbal in the hospital; one written in the rest home; and three verbal in the dementia unit indicated that they had been actioned according to timeframes and identified resolution. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery.</p> <p>All of the complaints have documentation and management of a full investigation, follow ups and resolution including communication with complainants. The village manager and the assistant manager manage the complaints and report to the others in the management team including the clinical manager.</p> <p>Residents and family confirm they are aware of the complaints process and they would make a complaint to the managers if necessary.</p> <p>There are no complaints with the Health and Disability Commissioner, DHB or MoH.</p>

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

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

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

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.

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

Outcome 1.2: Organisational Management

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

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

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

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

Attainment and Risk: FA

Evidence:

Evelyn Page's Care Centre is a modern facility that is part of a wider Retirement Village. The service provides rest home, dementia and hospital level care for up to 137 residents, including 20 certified serviced apartments. Occupancy is 27 rest home residents in the care centre plus 11 rest home residents in the serviced apartments, 53 hospital residents and 35 residents across the two secure dementia units.

1st floor – 40 bed unit includes 20 dedicated rest home beds and 20 rest home / hospital swing beds.

2nd Floor – 40 bed unit (hospital) includes 40 hospital residents.

3rd floor – two separate secure units (total 37 beds).

There is a medical component to the certificate and there are currently no residents under this. There is a contracted physiotherapist who comes into the service daily and a physiotherapy aid who provides 15 hours a week support. The manager described a link to a community dietitian if required. There are house doctors from a local medical centre who visit three days a week. There is one respite resident in the dementia unit.

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

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

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

Each service also has their own specific RAP objectives and for Evelyn Page in 2013 this includes; a) actioning resident survey results, b) leadership forum, c) monitoring wounds/weights , and d) decrease falls and UTIs.

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

ARC,D17.3di (rest home), D17.4b (hospital), the village manager and clinical manager has maintained at least eight hours annually of professional development activities related to management.

The service has in place a village manager that commenced in June 2008 at Grace Joel Retirement Village. He relocated as village manager to Evelyn Page July 2011. His background includes 15 years in Sales & Business Management roles in the Health Sector.

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.

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

Criterion 1.2.1.3 (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.

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 1.2.2: 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

Attainment and Risk: FA

Evidence:

D19.1a; A review of the documentation, policies and procedures and from discussion with staff identifies that the service operational management strategies, quality and risk management programme which includes culturally appropriate care, is to minimize risk of unwanted events and enhance quality of service delivery for residents and other stakeholders.

In the temporary absence of the village manager, the assistant manager fulfills the operational duties with support from the clinical manager. She is able to describe the role of providing leadership in the absence of the village manager with the support of the regional and systems managers.

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

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

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 1.2.3: 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

Attainment and Risk: FA

Evidence:

Evelyn Page has a well-established quality and risk management system that is directed by head office. The RAP includes a schedule across the year for

the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Evelyn Page through the onsite monthly RAP meetings and weekly management meetings.

Quality and risk performance is reported across the facility meetings and also to the organisation's management team.

Discussions with five registered nurses, two unit coordinators, activities coordinators and 10 caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities. The monthly staff meeting includes discussing and planning of the 2013 quality goals for the year and the objective are reviewed quarterly with evidence of progress against goals.

Resident meetings are held on a two monthly basis in the rest home and in the hospital. Relative meetings are held six monthly in each of the three areas. Resident and relative meetings identify follow through of actions required. Annual resident and relative surveys are completed. The last resident and relative survey was completed in November 2012, action required link to the 2013 quality objectives.

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar. There are adequate clinical policies and procedures to rest home, dementia and hospital level care including pain management, continence, personal grooming, skin integrity, wound management. The monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles and provides registered nurses and enrolled nurses with clinical knowledge and evidence to support decision making.

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

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

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings that also include review of infection control and of incidents. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies.

Ryman has tertiary level ACC WSMP. The organisation's benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

D19.2g Falls prevention strategies such as hi lo beds, completion of the post falls protocol, landing mats, physiotherapy assessments, regular checks, sensor mats are in place.

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

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

A spot audit is completed by head office against the standards - last in August 2013. There is a corrective action plan for each with timeframes related to

risk. Action plans evidence resolution of issues.

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.

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA
Evidence: D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing The village manager is able to identify that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH, changes in managers. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. A review of incidents in files across the three areas indicated that any falls have a post falls analysis completed and neurological observations are completed when applicable (sighted for three residents who had falls that involved a head injury). The data is tabled at meetings held in the facility including minutes of the monthly RAP committee meetings, registered nurse/enrolled nurse meetings, two monthly health and safety meetings and monthly full facility meetings. A six monthly comparative analysis is completed of incidents for internal benchmarking across Ryman's facilities. In addition, each facility receives an analysis of the last three six monthly periods from which to identify trends and improvements. Falls rates are compared to an indicators from the "Standard

on safe indicators in aged care".

A review of 17 incident/accident forms across the three areas identified that all are fully completed and include follow-up.

A sentinel event July 2013 occurred where the van on an outing hit a post when being parked. The incident was reported to police, and MoH. The DHB were not informed until 9/8/14. The service apologised for this oversight. The service completed an internal review of policies and procedures and as a result updated the Adverse Event Reporting policy and Incident – Suspicious Circumstances policy.

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

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

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

Criterion 1.2.4.3 (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.

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 1.2.7: 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

Attainment and Risk: FA

Evidence:

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

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files were reviewed. Staff training records are maintained. Annual performance appraisals are completed and up to date. Evelyn Page has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, H&S rep, clinical manager and gardener. The orientation/induction training for caregivers, on completion, is equivalent to foundations level two. There is a specific employees' induction manual. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent. The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment.

The 2012/2013 in-service training programme identifies at least 2-3 in-service sessions monthly. Registered nurses are supported to maintain their professional competency and there is also a foreign trained nurse development programme. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. Interviews with two registered nurses and one enrolled nurse identified that participation in the RN Journal Club is used to advise current practice and provide clinical updates and guidance. Yearly formal performance review specific to RNs for reflective practice and setting goals including up skilling or other training or qualification goals.

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

E4.5f: There are 23 caregivers in the dementia unit, 15 have completed the required dementia standards, seven caregivers are in the process of completing and one is new and is working through their induction.

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

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

Attainment and Risk: FA

Evidence:

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

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.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The manager advised that staff turnover has been low. Interviews with 10 caregivers from across the three areas (morning and afternoon shifts) stated that overall the staffing levels are fine and that the management team including the RNs provide good support.</p> <p>There is appropriate registered nurse cover across the facility. In the hospital unit there is two rostered RNs in the morning shift, plus the Hospital Coordinator & the clinical manager, and two RNs on the afternoon shift. In the resthome there are two RNs in the morning shift and one RN on the afternoon shift. There are two registered nurses across the dementia units seven days a week (morning shift).</p> <p>The clinical manager and registered nurse coordinator in the rest home provide support to the rest home residents in the serviced apartment including maintaining and updating care plans.</p> <p>Six relatives interviewed (from across each area) all confirmed that staff were excellent.</p> <p>Interviews with seven residents (five hospital and six rest home) confirmed that staff numbers and response to call bells were overall good.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Policies outline security of records. Files are kept in a secure cupboards behind the nurses station in all areas. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse/enrolled nurse including designation. Each resident has an individual file that includes all relevant information. Medication files are kept in a separate folder and this is appropriate to the service.</p>

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.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.2.9.7 (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policies including:</p> <p>a) Entry of Resident to Services policy. The information booklet answers a number of questions around admission and entry processes. The clinical manager (CM) screens potential clients for entry to services and requests confirmation of level of care to be received the day prior to admission. Consultation occurs with the co-ordinators/registered nurses of the pending admission and specific needs to be met. Information gathered at admission is retained in resident's records. Six rest home residents and five hospital residents interviewed confirmed they received information prior to admission and discussed the admission process with the facility manager. Relatives (three hospital, one rest home and two dementia) interviewed stated they received sufficient admission information and had the opportunity to discuss the admission agreement with management.</p> <p>E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none">1. Minimising restraint.2. Behaviour management.3. Complaint policy. <p>D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract,</p>

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

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

E3.1 Four resident files were reviewed across the two dementia units and three include a needs assessment as requiring specialist dementia care. One resident has been assessed for respite care and has a short term admission agreement in place,

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.

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

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

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

ARHSS D4.2

Attainment and Risk: FA
Evidence: The right to appeal against assessment outcome policy states the manager at every stage will inform the resident/family and inform them of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the Needs Assessors or referring agency for appropriate placement and advice. Declining entry would occur if there are no beds available or the service is unable to provide the assessed level of care.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>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.</p> <p>Five registered nurses (RN) interviewed (rest home, two hospital, special care unit and new graduate RN) described the timeframes for the development and reviews of care plans and files. Clinical staff have attended in-service and refreshers on clinical care including nursing assessment, caregiver practical skills, communication, sexuality and intimacy, skin integrity, personal hygiene, first aid and challenging behaviour.</p> <p>Activity assessments and activities care plans have been completed by the activity therapists.</p> <p>A physiotherapist is contracted to the service for three hours daily. The physio is predominantly based in the hospital unit and follows up any referrals from the rest home and special care units. The physio completes new resident physio assessments, follow up any referrals and forwards instructions to the physio aid to continue treatments as required. The podiatrist visits regularly.</p> <p>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 and amended when current health changes. Four rest home (including one resident in the serviced apartment), four hospital and four dementia residents (included one respite) files were reviewed. 11 long-term files identified the initial admission assessments and plans and long-term care plan were completed by the registered nurses within a three-week timeframe. The dementia care respite care resident had a full nursing assessment, risk tool assessments and care plan in place.</p> <p>D16.5e; Medical assessments were documented in all 11 long-term resident files within 48 hours of admission. The respite dementia care resident had been seen by the general practitioner prior to admission and had current medical and medication information from the GP in the resident file.</p> <p>Three monthly medical reviews were documented in 11 of 11 permanent resident files by general practitioner. It was noted in the resident files reviewed that the GP has</p>

assessed the resident as stable and is to be seen three monthly. More frequent medical assessment/ review is noted occurring in residents with acute conditions and those requiring palliative care. The GP (interviewed) visited a palliative care resident and commenced the Liverpool care pathway. The family (interviewed) spoke highly of the staff, clinical and medical care. They state they have been kept fully informed and involved in end of life decisions. The service is supported by Hibiscus hospice nurses and specialists as required.

Medical care is provided by a medical centre with a GP's contracted for each of the levels of care. The GPs visit their residents weekly and are available to attend to other residents of concern during their routine visit. The GP service is available after hours by mobile phone and provide an on call telephone service. The GPs are involved in the three monthly multidisciplinary (MDT) reviews. GPs receive faxes from the RNs regarding any resident concerns. The GP stated the RN concerns are appropriate and has confidence in the RN clinical assessments.

10 caregivers interviewed (three dementia, three rest home, one serviced apartments, three hospital) who work across morning and afternoon shifts could describe a verbal handover and written handover book which details any resident concerns, incidents, infections and any other significant concerns.

Progress notes are written on every shift. RN's, EN's, caregivers attended toolbox in-service on progress notes February 2013 and documentation education March 2013.

The service have a number of visiting nurse practitioners such as the gerontology nurse specialist, mental health nurse specialist and dementia nurse specialist who are all based at the Waitemata DHB. The nurse specialists liaise closely with the GP, medical specialists and consultants to ensure a continuity of care.

Tracer methodology; Hospital Tracer

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

Rest Home Tracer

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

Dementia care resident

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

Criterion 1.3.3.1 (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.

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

Criterion 1.3.3.3 (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.

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

Criterion 1.3.3.4 (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.

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

Standard 1.3.4: 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

Attainment and Risk: FA
Evidence: The following personal needs information is gathered during admission (but not limited to): personal and identification and Next of Kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food &

nutrition information and mental function.

Risk assessment tools and monitoring forms are available to assess (if applicable) level of risk and required support for residents including (but not limited to); a) waterlow pressure area risk assessment, b) skin integrity, c) continence, d) coombes falls risk, e) dietary profile f) pain/Abbey scale assessment g) physiotherapy assessment. h) behavioural assessment i) nutritional needs screening tool j) wound assessment k) restraint assessment. Assessments are reviewed when there is a change to condition or at least six monthly. A full nursing assessment is completed on admission.

ARC E4.2; Four dementia resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a Challenging behaviours assessments are completed in four of four special care unit resident files (includes one respite care resident)

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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The long term care plans include nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality. Interview with five registered nurses and four clinical co-ordinators verified involvement of families in the care planning process. RN's and EN's have attended care planning and documentation training March 2013. Each area of the care plan includes: problems/needs, objectives and interventions. Four of rest home, four hospital and three of four special care unit residents have current long term care plans that reflect the resident's current needs (one is a respite).</p> <p>Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as physiotherapist, podiatrist, dietitians, hospice and MHSOP. Allied health professionals involved in the residents care is linked to the long term care plan. The activities co-ordinators develop individual activity care plans.</p> <p>Physiotherapy progress notes, podiatry, medical and other allied health visits are documented in the integrated resident file.</p>

E4.3 Two of four special care resident files included a behaviour assessment and behaviour nursing care plan identifying current abilities, level of independence, identified needs and specific behavioural management strategies. (link 1.3.6.1)
 D16.3k, Short term care plans are in use for acute events or changes in health status. Examples sighted are as follows: weight loss, skin tear, cellulitis, toothache, rash, wounds, chest infections, behaviour management and skin care.
 D16.3f; 12 of 12 resident files reviewed identified that family were involved. Relatives interviewed confirm they are involved in the care planning process.
 Resident/relative/whanau sign acknowledgment of care plan document.

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

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

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Twelve resident files were reviewed (four rest home, four hospital, three special care unit and one special care unit respite care). Residents interviewed (five hospital, six rest home) report their needs are being appropriately met. Relatives interviewed (three hospital, two dementia care and one rest home) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use in each unit. Wound assessment and wound management plans are in place for two chronic leg ulcers (one person) and two leg wounds in the special care unit, three wounds in the rest home and three pressure areas (two heels and one ankle - two residents) in the hospital unit. Short term care plans are in place for wounds and skin tears. Chronic wounds are linked to the long term care plans (sighted). Each unit wound folder has a wound and skin tear register. Evaluations, wound assessments and pain level is carried out at each dressing change and signed by the RN. Wound mapping charts and photographs are evident as required. An RN is the wound care nurse for the service. The service has access to a wound care specialist at Waitemata DHB. Twenty staff attended wound care management provided in March and May 2013. The RNs interviewed state there are adequate pressure area resources including alternating air mattresses and cushions.

Continence products are available and resident files include a three day diary continence assessment to identify urinary incontinence, bowel management, and continence products for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the four RN's interviewed. Continence management has been attended January 2013 (22 staff).

Weigh chair scales (calibrated November 2013) are used to weigh residents monthly. At risk residents and those with unintentional weight loss are monitored more frequently. Weight loss short term care plans in place include interventions listed as fortnightly weigh, drink supplements, food and fluid monitoring, frequent in-between snacks, high protein diet, GP and kitchen notification and dietitian referral. The dietitian develops individual diet plans for residents as necessary. The service has introduced "smoothie" rounds to all the units. Staff are observed in the special care unit sitting with residents at meal time and providing assistance with the meal and feeding residents as necessary. Alternative foods are offered to encourage eating.

Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment form for at risk residents. Accident incidents are investigation for cause and corrective actions include the use of sensor mats, clutter free rooms, supervision and use of mobility aids. A repeat falls analysis is completed for frequent fallers and post monitoring form is commenced which included observations, pain ad any neurological recordings as appropriate. A referral is initiated for physiotherapy involvement. Staff have attended moving and handling education and fall prevention in-service.

Pain assessments are completed on admission and reviewed six monthly or earlier for any exacerbation of pain or new episodes of pain. The effectiveness of pain relief is monitored and documented in the progress notes. Abbey pain scale is completed for residents in the special care unit. Chronic pain is linked to the long term care plan. Pain management is reviewed three monthly at the GP review and evaluated with the six monthly care plan review. Pain management education was provided July 2013.

Staff complete monitoring charts and forms as instructed such as toileting and turning charts, food and fluid monitoring, fluid balance charts, diabetic blood sugar levels and weight charts

Challenging behaviour assessments are completed for four of four special care unit residents. There is an improvement required regarding the documentation of specific interventions/distractions and activities (over a 24 hour period) in the behaviour care plan and behaviour monitoring forms.

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.

Attainment and Risk: PA Low
Evidence: Challenging behaviour assessments are completed for four of four special care unit residents. Behaviour nursing care plans identify behaviours, triggers and interventions/distractions to de-escalate disturbing behaviour in two of four special care unit resident files. Behaviour monitoring charts are in place for residents with known challenging behaviours. 54 staff attended challenging behaviour in September 2013.
Finding: i) Two of two special care unit resident nursing behaviour charts do not specify alternative strategies/activities for de-escalation of behaviours. ii) Two of two special care unit resident behaviour monitoring charts record "re-direct" to de-escalate behaviour. iii) Two hospital residents' behaviour monitoring charts record the administration of haloperidol for "restless" behaviour. The use of prn medication does not align with the medication signing sheet, progress notes and behaviour monitoring chart.
Corrective Action: i) Ensure behavioural nursing care plans include specific alternative strategies and activities that cover a 24 hour period for the de-escalation of disturbing behaviour. ii) Ensure specific alternative strategies to de-escalate disturbing behaviour is recorded on behaviour monitoring charts used. iii) Ensure alternative strategies are documented on the behaviour monitoring as attempted to de-escalated behaviour before the use of prn medication
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

Attainment and Risk: FA
Evidence: There are 10 activity coordinators who implement activity programmes across the village, serviced apartments, rest home, hospital and special care unit. There is also an assigned lounge person (4-8pm) that supervises and provides activities to the residents in the special care unit as well as a weekend activity person. The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility. Each unit has its own programme that meets the needs of the consumers. Residents may attend combined entertainment in the Atrium. Outings, happy and entertainment is designed to meet the consumer group and individual needs. Special care unit activities are focused around household activities such a baking, sensory stimulation and reminiscing. Music and entertainment is enjoyed and drives and outings occur twice weekly. Residents are taken for supervised walks daily outside or to the atrium if wet weather. Hospital residents enjoy regular entertainment, crafts, and wheelchair taxi outings to the RSA, cafes, and picnics. One on one activities take place with residents including manicures, massage, conversation, and wheelchair walks, Rest home activities include news and views, bingo, floor games, movies, cards, blokes club, gardening group. Outings include inter home visits, bowls, RSA and Age concern community group. Guest speakers are invited to the village and there are groups such as cubs, brownies, schools and kindergarten children, guide dogs and travel calendar speakers involved in the programme. The triple A (Active, Ageless, Awareness) exercise programme was designed by the Ryman group and includes chair exercises for less active residents and more active

exercise programme for mobile residents and serviced apartments. There are different levels of the programme depending on the mobility level of the residents. Hymn and prayer meetings, church services and holy communion are held in each of the areas.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed within 21 days and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences', Next of kin input into care and an activities care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. The activity care plan is reviewed six weeks post admission and six monthly thereafter with the RN, GP, and family/resident. The activity liaise closely with the carers. A communication diary is used. The activity co-ordinators have a handover with the RN daily.

The programme is evaluated and can be individually tailored according to resident's needs. Bi-monthly resident meetings are held with the village manager. Six monthly family meetings are held for the special care resident families. Feedback on the activity programme is also received from internal audits and resident surveys.

The activity team described the implementation of the 'Spice of Life', a resident focused programme to enable the village to support residents achieve self-setting goals. Residents are able to participate in community activities as well as activities in the service itself. There is a resident choir and a knitting group.

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

Hospital and rest home residents and family members (rest home, hospital and dementia) interviewed discussed enjoyment in the programme and the diversity offered to all residents.

The activity team all have current first aid certificates and have completed defensive driving courses. They attend relevant in-service offered and attend the diversional therapy workshops as scheduled.

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

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.

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

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

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

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

Attainment and Risk: FA

Evidence:

The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). Short term care plans are utilised in the rest home, hospital, and special care unit. Short term care plans are evaluated regularly and either resolved or added to the long term care plan if an on-going problem. The MDT (RN, Physio, GP, Diversional therapist and dietitian) complete resident reviews at least six monthly. Family are invited to attend review meetings by letter (correspondence noted in files sighted). Any changes to the long term care plan are dated and signed by the RN. The GP reviews the resident medications at least three monthly. Activity care plans are reviewed at the MDT reviews.
D16.4a Care plans are evaluated six monthly more frequently when clinically indicated
ARC: D16.3c: All initial care plans are evaluated by the RN within three weeks of admission

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Four RN's interviewed state they initiate referrals to nurse specialist services. The GP is notified of any nurse specialist referrals. The GP initiates any specialist or consultant referrals. Referrals and options for care are discussed with the family as evidenced in medical notes and relative contact forms in the resident files. Referrals sighted on the resident files sampled are as follows: podiatry, physiotherapy, dietitian, stroke clinic, palliative nurse , wandatrak alarms and mental health services for the older person D16.4c; The service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care. D 20.1 Discussions with four registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists.</p>

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

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

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

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

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

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

Transfer information is completed by the registered nurse or clinical service manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. The transfer of residents or admission to other provider's policy includes instructions for documentation and whom to notify. One hospital file reviewed of a resident transferred acutely to hospital identified that a transfer form and DHB yellow envelope checklist was completed and family notified. A discharge summary and nursing discharge summary is evident in the residents file when transferred back to the facility. Relatives interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

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 individualised medication blister packs for regular and PRN medications. The medications are delivered monthly and checked in by the RN on duty and any discrepancies are fed back to the supplying pharmacy. Medication delivery faxes are checked off on delivery and filed. There are locked pharmacy return boxes available. Medications are stored in locked trolleys within locked rooms in each unit. All eye drops in use are dated on opening. Controlled drugs safes are located in the medication rooms for hospital, rest home and special care unit. There are weekly controlled drugs checks sighted in controlled drugs registers. The six monthly pharmacy audit was last completed November 2013. Liverpool care pathway controlled drugs are kept in the hospital controlled drugs safe. The serviced apartments use the rest home controlled drugs safe and medication fridge if required. Medication fridge's are monitored weekly (records sighted) however there is an improvement required around the hospital medication fridge temperature. There is a list of medication competent RN's and caregivers. All senior caregivers/RNs /EN's administering medication complete a medication orientation package and six monthly medication and insulin competencies. Medication training last occurred June and August 2013. Medication administration observed in the special care unit met the required standards. PRN medications have the time of administration on the signing sheet. Controlled drugs are signed by two persons. Standing orders are available. There are two self-medicating residents in the rest home. Each resident has a self-medication assessment that is reviewed six monthly by the RN and GP. The medication is stored safely in the resident's room (sighted). There is evidence of regular monitoring. 24 Medication charts sampled (two serviced apartments, six rest home, eight hospital, eight dementia) record prescribed medications by residents' general practitioner, including PRN and short course medications. All medication charts have photo identification and allergies/adverse reactions documented. There are special instructions for the crushing and administration of medications. D16.5.e.i.2; 24 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed. Oxygen and suction and emergency trolley is checked weekly.

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.

Attainment and Risk: PA Low
Evidence: Medication fridge's are monitored weekly (records sighted).
Finding: There is no corrective action taken for the hospital medication fridge temperatures consistently outside of the acceptable range.
Corrective Action: Ensure corrective action is taken to maintain the medication fridge temperature within the acceptable range.
Timeframe (days): 60 (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.

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a head chef, sous chef, kitchen assistant and dishwasher (morning and afternoon) on each day to prepare and cook the meals. All cooking and baking is done on site. The four weekly summer and winter menu is designed and reviewed by a Registered Dietitian at an organisational level. The menu can be changed in consultation with the dietitian to accommodate resident choice. Breakfast is prepared and served in the unit kitchenettes. Each kitchenette has a fridge, dishwasher and microwave. The chef receives a resident dietary requirement for each new admission and changes to resident's dietary needs are communicated to the kitchen. Special diets and requests are written up on the kitchen whiteboard for easy reference. Resident menu cards are available in each unit for the serving of meals. Special diets (gluten free, vegetarian, irritable bowel diets) and resident likes/dislikes are known by kitchen staff. The chef is notified if the dietitian has been involved in any residents with dietary concerns such as weight loss/gain or swallowing difficulties. "Smoothie" rounds have been introduced in all units and the kitchen have charts for the making up on dietary supplements. Additional nutritious snacks are available in the special care unit such as yoghurts, complans, biscuits, and fruit. Containers of freshly made sandwiches are delivered to the special care units at meal times as an alternative for residents not wishing to eat the main meal. Diabetics are catered for as required with diabetic baking, protein sandwiches, diabetic ice-cream and fresh fruit.

All meals are transported to the serviced apartments, rest home, hospital and dementia units in insulated containers. Trays of food are then removed from the insulated transfer boxes and placed in warmed bain maries. Hot food temperatures are monitored twice daily. Three monthly internal audits on food temperature monitoring are 100%. All perishable goods in the fridges and chillers are dated.

The service has a large workable kitchen that contains a walk-in chiller, four freezers walk-in pantry, electric oven, gas hobs and two combi ovens. The kitchen has a separate dishwashing area, baking, cooking, delivery and storage areas. The freezer and chiller temperatures are recorded twice daily. Corrective action is taken when temperatures are outside of the acceptable range (records sighted). The kitchen equipment is on a planned maintenance schedule. The chemical supplier provide the chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. The chemicals are stored safely.

There's a pest management programme in place and fly screens on the windows.

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.

Feedback on the service is received from resident and staff meetings, surveys and audits. There is a food comment book in the dining rooms. Positive comments noted on the meal service. The chef checks the comments weekly and responds.

E3.3f, There is evidence that there is additional nutritious snacks available over 24 hours

D19.2 The head chef hold a diploma in catering and chef qualifications. All kitchen staff have been trained in safe food handling and chemical safety.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

There are implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. General waste bins are collected by a contractor. Recycling occurs. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. Chemicals are delivered to a locked chemical store shed. Chemicals in use are stored safely throughout the facility. Safety data sheets and products charts are available. Relevant staff have attended chemical safety training.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Legislation and regulatory requirements appear to be met for local authorities and the MoH. The building holds a current warrant of fitness, which expires on 6 September 2014. There is a full time (and on call) maintenance person to carry out building maintenance on request and planned maintenance as scheduled. The maintenance person co-ordinators contractors as required and reports to the property manager at head office weekly. External contractors are in place for the maintenance of external wall coverings, carpet cleaning and window cleaning (internal and external). Records are maintained (sighted). There is access to necessary and essential equipment. All clinical equipment has been tested for function and calibrated as required. There are maintenance policies and procedures in place including electrical checks and a Preventative Maintenance schedule being implemented for 2013. Hot water temperatures are monitored three monthly. Health and Safety meetings include maintenance and preventative maintenance.</p> <p>Residents have access to a library, shop, hairdresser and chapel within the facility.</p> <p>The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Hand rails are available around the hall ways. There is adequate space around the facility for storage of mobility equipment.</p> <p>There are outside areas with shade and seating that is observed to be well maintained. Three gardeners are employed to maintain the grounds and gardens. There is a central covered atrium with gardens and seating.</p> <p>E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities. Each special care unit has its own open plan lounge and dining area. The doors between the units can be opened up during the day for shared entertainment.</p> <p>ARC D15.3; The following equipment is available, pressure relieving mattresses and cushions, shower chairs, chair scales (calibrated November 2013), sensor mats, sling and standing hoists (checked November 2013), transferring and mobility aids. Interviews with 10 caregivers and five RN's working across all the units and varying shifts confirmed there was adequate equipment.</p> <p>E3.3e: There are quiet, low stimulus areas that provide privacy when required. There are smaller quiet rooms for individual activity or visitor use.</p>

E3.4.c; There is a safe and secure outside area that is easy to access with raised gardens, edible plants and shaded seating areas.

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

All buildings, plant, and equipment comply with legislation.

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

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.

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

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.

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

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

Attainment and Risk: FA
Evidence: All resident rooms have ensuites. The ensuite floors are safe and easy clean vinyl surfaces. Handrails are appropriately placed in the toilet shower areas. There is a call bell system within easy reach. Communal toilets (clearly identified) are located near the lounges. .

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.

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 1.4.4: 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

Attainment and Risk: FA

Evidence:

Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. Bedrooms are personalized. Bedroom doors in the special care units have door photographs to aid resident identification of their room.

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

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

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 1.4.5: 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

Attainment and Risk: FA

Evidence:

Each area has at least two lounges. There is also a family room and separate dining areas on each floor. The communal lounge/dining room in the serviced apartments is spacious and allows for a number of different activities. There is a separate dining area in the large open plan living area in the secure unit. Activities take place in a

number of areas within the facility. Residents are observed as freely access the communal areas with the use of mobility aids
E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. There are internal and external walking pathways. The corridors are wide with handrails.

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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. Linen service audit for September 2013 showed 100% compliance and housekeeping hygiene for September 2013 was also 100%. The service employ dedicated laundry and cleaning staff.</p> <p>The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the cleaning cupboards and there is secure chemical storage areas. Cleaner's trolleys are well equipped. The laundry and cleaning areas have hand-washing facilities. Cleaning schedules are maintained. There are adequate linen supplies sighted. Staff interviewed are knowledgeable in the use of equipment and infection control practices. Staff have attended chemical safety, safe manual handling, elder protection, code of rights and other relevant education as offered.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: All staff attends fire drill/civil defence training. All registered nurses have current first aid certificates. The fire evacuation plan is a requirement of the CPU and was approved 12 April 2010. The civil defence kit is monitored as part of the RAP programme and includes supplies for at least three days including water supplies. There is

an appropriate call system. A fire register folder, which contains information on each resident and the level of assistance, required in the event that the facility requires evacuating is kept at the nurses' station on each floor. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training.

Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms in the 1st and 2nd floor and emergency bells in all rooms on the 3rd floor. All staff carries a pager that is connected to the call bell system on each floor. The Oslo night security system in the dementia units is also connected up to the call bell system.

There is an entrance and reception area in the 2nd floor (entrance level). The entire facility is secured at night. The service utilises security cameras and an intercom system. Visitors book available. The Ryman group has an adequate security checks policy and procedure. A security firm provides external surveillance overnight.

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

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

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

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

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

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

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

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 1.4.8: 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

Attainment and Risk: FA

Evidence:

General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility. All rooms have external windows with plenty of natural sunlight.

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (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.

Attainment and Risk: FA

Evidence:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
<p>Evidence:</p> <p>There is a restraint minimisation manual applicable to the type and size of the service.. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.</p> <p>The restraint minimisation manual includes that enablers are voluntary and the least restrictive option. There are eight bedrails identified as enablers and 17 restraints used in the service.</p> <p>Two enabler files were reviewed and included consents and assessments.</p> <p>E4.4a: the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour</p>

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

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

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

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

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

Attainment and Risk: FA
Evidence: The restraint coordinator is the clinical manager who is an RN experienced in aged care. Assessment and approval process for a restraint intervention includes the RN, resident/or representative and medical practitioner.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. A registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In two of two restraint files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family involvement and a specific consent for enabler / restraint form is used to document approval.

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

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

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

Attainment and Risk: 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 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

Attainment and Risk: PA Low

Evidence:

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two files reviewed. A three monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is up dated each month. Two restraint files were reviewed for residents with three identified forms of restraint.(bed rail, lazyboy and table). The care plans did not identify the three forms of restraint or interventions to manage. The restraint monitoring form (while completed) did not identify which form of restraint was in place

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

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

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

Attainment and Risk: PA Low

Evidence:

The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two files reviewed. A three monthly evaluation of restraint is completed that reviews the restraint episode.

Finding:

Two restraint files were reviewed for residents with three identified forms of restraint. (bedrail, lazyboy and table). The care plans did not identify the three forms of restraint or interventions to manage. The restraint monitoring form (while completed) did not identify which form of restraint was in place.

Corrective Action:

Ensure care plans reflect interventions to manage assessed restraints. Ensure monitoring forms reflect which restraint is in place.

Timeframe (days): 90 (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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 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.

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

Services evaluate all episodes of restraint.

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

Attainment and Risk: FA

Evidence:

The service has documented evaluation of restraint every month. The restraint process considers the items listed in # 2.4.1. In the two restraint files reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every three monthly by the facility restraint co-ordinator and through the RAP meeting. Evaluation timeframes are determined by risk levels.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

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

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.

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

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

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

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

Attainment and Risk: FA
Evidence: The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported to the monthly RAP meetings and six monthly restraint approval group.

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.

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

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

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

Attainment and Risk: FA
Evidence:
<p>There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There are policies including a) a scope and application of the NZ standard for IC policy, b) infection control management policy, c) infection control governance policy, and d) defined and documented IC programme policy. There are clear lines of accountability to report to the infection control (IC), team on any infection control issues including a reporting and notification to head office policy. There is an infection control responsibility policy that includes chain of responsibility and an infection control officer job description.</p> <p>The defined and documented IC programme policy states that the infection control programme is set out annually from head office and is directed via the Ryman Accreditation Programmes annual calendar.</p> <p>The annual review policy states IC is an agenda item on the two monthly head office health and safety committee. Evelyn Page also undertakes a six monthly comparative summary report on all infections that is reported to staff (last completed in March 2013).</p>

The service infection control manual includes a policy on a) admission of resident with potential or actual infections policy, b) infectious hazards to staff policy, c) outbreak management d) staff health policy and e) isolation policy.
There have been no outbreaks since the previous audit

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

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

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

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

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

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

Criterion 3.1.9 (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.

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: There are terms of reference for the health and safety committee that includes discussion of infection control. The infection control coordinator (clinical manager) facilitates the surveillance programme with reports around data provided, organises training with Med lab and other IC specialists, implements and reviews internal audits as evident in documentation reviewed. The infection control coordinator has completed the infection control packages from head office.

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.

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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.

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

Infection control training is provided by the infection control coordinator. Training in 2013 has included infection control (September 2013), safe food handling (September 2013).

Resident education is expected to occur as part of providing daily cares. Support plans include ways to assist staff in ensuring this occurs.

Resident and relative meeting minutes include feedback on infection prevention and control.

The clinical manager describes sound infection control practices being overseen by the registered nurses.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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 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.

Attainment and Risk: FA

Evidence:

The surveillance policy states the routine/planned surveillance programme is organised and promoted via the RAP calendar. The health and safety committee meets two monthly and also acts as the infection control committee. A monthly infection summary report is completed. Review of the minutes indicates that any trends are discussed with improvements made.

The surveillance includes a) systematic surveillance, b) response to surveillance activities, c) development of the surveillance programme, d) standardised definitions, e) surveillance methods, f) reports and g) assessment of effectiveness of surveillance.

Surveillance methods and processes including implementation of an internal audit are appropriate for the size of this facility (rest home and hospital level). All infections are collected via the 'infection report form', all collected, and discussed at the RAP meetings. Following this, the report information is entered onto the VCare system and a collated report of generated.

Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.

The infection control coordinator then completes a monthly infection summary, which is discussed at bimonthly health and safety meetings, and a six monthly comparative summary is completed and forwarded to head office. Infections are benchmarked across the organisation

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.5.7 (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.

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.)