

Molly Ryan Lifecare (2007) Limited

Current Status: 4 February 2014

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

Molly Ryan Lifecare is located in New Plymouth. The facility provides rest home, hospital and assisted living care, if requested, in apartments. Twenty-seven apartments are already certified to provide resthome care and as part of the certification audit five of these independent apartments were assessed as being suitable for hospital or rest home level if required.

There were no areas requiring improvement as a result of this audit.

Audit Summary as at 4 February 2014

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 4 February 2014

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 4 February 2014

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 4 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 4 February 2014

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 4 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 4 February 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Audit Results as at 4 February 2014

Consumer Rights

On admission to Molly Ryan Lifecare residents and their families are given a comprehensive information package, which includes the Health and Disability Services Consumers' Rights (the Code), and information about the Nationwide Health and Disability Advocacy Service. These are discussed at the time of admission, and further discussions are held as required. Posters detailing residents' rights are displayed round the facility, and brochures on the Advocacy Service are prominently displayed at reception. Information on the Code is included in the regular residents' newsletter. The admission agreement details inclusions and exclusions of service. Staff receive education on consumer rights as part of their orientation and ongoing education, and demonstrated sound knowledge and understanding of the Code.

Service delivery is resident-centred and meets legislative requirements. Comprehensive assessments are utilised to develop individualised plans of care for residents that meet their ethnic, cultural and spiritual values. Open disclosure principles are demonstrated, and there is evidence of effective and open communication with families.

Molly Ryan Lifecare ensures that care delivery is based on current good practice, and maintains strong networks with a range of health care providers and aged care consultants.

Molly Ryan Lifecare has an open visiting policy, and residents are also encouraged to access community services, and maintain their links with the community and their families. A dedicated mobility van provides ease of transport for residents, and there are regular shopping trips and other outings.

Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The

philosophy, vision, scope and goals are appropriate for the service. The general manager, who is also a qualified registered nurse, has appropriate experience and qualifications to perform this role and is responsible for the overall service delivery, business administration, quality systems and human resources management. The general manager is supported by a full time clinical nurse leader and has support and advice from the four registered nurses on staff for the clinical aspects of service delivery.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme for 2013 was in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery in the rest home and hospital. Rosters reviewed and staff interviewed demonstrated that an appropriate number of skilled and experienced staff is allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for 2013 and education records are well maintained.

Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Continuum of Service Delivery

Prior to admission, residents must be assessed for entry by the Taranaki Community Support Services to confirm they require the services provided by Molly Ryan Lifecare.

A registered nurse completes an initial assessment of the resident and develops a short term care plan within 48 hours. A long-term care plan is then developed within three weeks, and there is evidence of multidisciplinary input, including the resident and their family, into the plan. Plans are evaluated every six months as part of a multidisciplinary review, or earlier if required. Residents and families confirm their input into the care plan development, and its evaluation. Clinical notes are integrated, with input from all care providers documented.

Service delivery is undertaken by appropriately qualified staff. Registered nurses are on duty 24 hours a day and provide support and guidance to delivery staff. A physiotherapist reviews all residents on admission, and residents are able to retain their general practitioner. Molly Ryan Lifecare has well-established relationships with a range of specialist services at the Taranaki District Health Board (TDHB), and also makes effective use of a range of external aged care consultants in relation to service delivery and planning. There is evidence of appropriate and timely referrals to specialist services.

An experienced diversional therapist, who is currently undertaking the diversional therapy training, is present for 30 hours each week to manage the activities programme. The programme is varied and offers a wide range of one-on-one and group activities, including outings in the facility van.

The medication management system is appropriate and safe and meets all legislative requirements. All medications are administered by either a registered nurse or an enrolled nurse. Several residents self-administer medication and there are robust processes to support this.

Food service policies and procedures are appropriate and comply with current legislation and guidelines. Meals are well presented and nutritious. While all residents have breakfast in their rooms, the spacious and attractively furnished dining room is a popular lunchtime venue.

The preferences and food requests of residents are catered for on an individual basis, and the kitchen staff have appropriate food safety qualifications.

Safe and Appropriate Environment

Molly Ryan Lifecare provides rest home and hospital care in the same building. The existing rest home/hospital building has a current building warrant of fitness. The evacuation plan is approved by the fire service.

There are documented processes for the management of waste and hazardous substances in place. Visual inspection evidences compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by service providers. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. The laundry service is provided by an externally contracted organisation. The service complies with requirements related to safe and hygienic storage of cleaning/laundry equipment and chemicals.

The building has appropriate systems in place to ensure the residents' physical environment is fit for their purpose. All buildings, plant and equipment comply with legislation. The internal and external areas of the building are safe and secure for residents of all levels of care. Documented systems are in place for essential,

emergency and security services, including a comprehensive disaster and emergency management plan. Emergency equipment and supplies are checked regularly. Alternative energy and utility sources are maintained.

The rest home/hospital has an appropriate call system for residents to request assistance from staff.

Restraint Minimisation and Safe Practice

The service has a restraint free environment and does not have any recorded restraint or enabler use. The care is flexible and individualised to promote quality of life that minimises the need for restraint through effective management of challenging behaviours. The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard.

Infection Prevention and Control

Molly Ryan Lifecare offers a well-managed environment which minimises the risk of infection to residents, staff and visitors. An infection control team, who are appropriately qualified for their role, are responsible for infection prevention and control within the facility. Infection control is a standing agenda item at the quality committee with clear lines of reporting evident. There is evidence of ongoing surveillance, analysis of results, and appropriate interventions, and appropriate safety equipment, such as gloves and hand sanitisers, readily available.

An external infection control and prevention consultancy service supplies the infection control manual, which is updated on an annual basis, undertakes an annual review of the service, and contributes to regular staff education.

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:	Molly Ryan Lifecare (2007) Ltd
Certificate name:	Molly Ryan Lifecare
Designated Auditing Agency:	DAA Group
Types of audit:	Certification
Premises audited:	269 Mangorei Rd, New Plymouth
Services audited:	Rest Home and Hospital
Dates of audit:	Start date: 4 February 2014 End date: 5 February 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	34

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	16	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	3

Sample Totals

Total audit hours on site	32	Total audit hours off site	19	Total audit hours	51
Number of residents interviewed	7	Number of staff interviewed	15	Number of managers interviewed	1
Number of residents' records reviewed	9	Number of staff records reviewed	8	Total number of managers (headcount)	1
Number of medication records reviewed	14	Total number of staff (headcount)	50	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Thursday, 27 February 2014

Executive Summary of Audit

General Overview

Molly Ryan Lifecare is located in New Plymouth. The facility provides rest home, hospital and assisted living care, if requested, in apartments. Twenty-seven apartments are already certified to provide rest home care and as part of the certification audit five of these independent apartments were assessed as being suitable for hospital or rest home level if required.

There were no areas requiring improvement as a result of this audit.

Outcome 1.1: Consumer Rights

On admission to Molly Ryan Lifecare residents and their families are given a comprehensive information package, which includes the Health and Disability Services Consumers' Rights (the Code), and information about the Nationwide Health and Disability Advocacy Service. These are discussed at the time of admission, and further discussions are held as required. Posters detailing residents' rights are displayed round the facility, and brochures on the Advocacy Service are prominently displayed at reception. Information on the Code is included in the regular residents' newsletter. The admission agreement details inclusions and exclusions of service. Staff receive education on consumer rights as part of their orientation and ongoing education, and demonstrated sound knowledge and understanding of the Code.

Service delivery is resident-centred and meets legislative requirements. Comprehensive assessments are utilised to develop individualised plans of care for residents that meet their ethnic, cultural and spiritual values. Open disclosure principles are demonstrated, and there is evidence of effective and open communication with families.

Molly Ryan Lifecare ensures that care delivery is based on current good practice, and maintains strong networks with a range of health care providers and aged care consultants.

Molly Ryan Lifecare has an open visiting policy, and residents are also encouraged to access community services, and maintain their links with the community and their families. A dedicated mobility van provides ease of transport for residents, and there are regular shopping trips and other outings.

Outcome 1.2: Organisational Management

Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals are appropriate for the service. The general manager, who is also a qualified registered nurse, has appropriate experience and qualifications to perform this role and is responsible for the overall service delivery, business administration, quality systems and human resources management. The general manager is supported by a full time clinical nurse leader and has support and advice from the four registered nurses on staff for the clinical aspects of service delivery.

The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A

comprehensive internal auditing programme for 2013 was in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management, reflecting current accepted good practice.

The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery in the rest home and hospital. Rosters reviewed and staff interviewed demonstrated that an appropriate number of skilled and experienced staff is allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for 2013 and education records are well maintained.

Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Outcome 1.3: Continuum of Service Delivery

Prior to admission, residents must be assessed for entry by the Taranaki Community Support Services to confirm they require the services provided by Molly Ryan Lifecare.

A registered nurse completes an initial assessment of the resident and develops a short term care plan within 48 hours. A long-term care plan is then developed within three weeks, and there is evidence of multidisciplinary input, including the resident and their family, into the plan. Plans are evaluated every six months as part of a multidisciplinary review, or earlier if required. Residents and families confirm their input into the care plan development, and its evaluation. Clinical notes are integrated, with input from all care providers documented.

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The preferences and food requests of residents are catered for on an individual basis, and the kitchen staff have appropriate food safety qualifications.

Outcome 1.4: Safe and Appropriate Environment

Molly Ryan Lifecare provides rest home and hospital care in the same building. The existing rest home/hospital building has a current building warrant of fitness. The evacuation plan is approved by the fire service.

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The rest home/hospital has an appropriate call system for residents to request assistance from staff.

Outcome 2: Restraint Minimisation and Safe Practice

The service has a restraint free environment and does not have any recorded restraint or enabler use. The care is flexible and individualised to promote quality of life that minimises the need for restraint through effective management of challenging behaviours. The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard.

Outcome 3: Infection Prevention and Control

Molly Ryan Lifecare offers a well-managed environment which minimises the risk of infection to residents, staff and visitors. An infection control team, who are appropriately qualified for their role, are responsible for infection prevention and control within the facility. Infection control is a standing agenda item at the quality committee with clear lines of reporting evident. There is evidence of ongoing surveillance, analysis of results, and appropriate interventions, and appropriate safety equipment, such as gloves and hand sanitisers, readily available.

An external infection control and prevention consultancy service supplies the infection control manual, which is updated on an annual basis, undertakes an annual review of the service, and contributes to regular staff education.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	5
Criteria	0	0	0	0	0	0	0	8

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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:

Document Review: The consumer rights policy and procedure sighted acknowledges how the service will ensure consumer rights are fulfilled. Resident rights are also reinforced through other policies, such as the informed choice and consent policy, and the complaints policy.

Details of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is provided in the resident admission pack. At the time of admission, the General Manager or Clinical Nurse Leader discusses the Code with the resident and their family, and there is ongoing discussion on an as-required basis. Information on resident rights is also included on a regular basis in the facility newsletter for residents. The Code is also displayed in poster form in a number of prominent locations around the facility. Information on the Nationwide Health and Disability Advocacy Service is also included in the resident admission pack, and copies of the brochure are prominently displayed in the reception area.

The Code is included in the orientation programme for all staff, and there are annual in-service education sessions which include the Code, resident rights and responsibilities. All personnel files reviewed demonstrate that staff have received training on the Code. On interview, care delivery staff (general manager, one registered nurse, one enrolled nurse, and six caregivers) demonstrate their understanding of resident rights, and how these are incorporated into their everyday practice. On interview, residents and family (seven of seven rest home residents, two of two family members) confirm their understanding of their rights, and awareness of the Health and Disability Advocacy Service. None of the three hospital-level residents were able to be interviewed.

During the audit, staff were observed to offer residents choices, to treat them with respect, maintain their dignity, and knock on their doors prior to entering.

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: <p>All residents receive a copy of the Code at the time of admission and this is discussed with them by the RN responsible for their admission. There is also opportunity for further discussion on an on-going basis as required. Posters with the Code are displayed in a number of locations throughout the facility.</p> <p>The Nationwide Health Advocacy Service brochure is prominently displayed at the reception desk, and the local advocate visits Molly Ryan Lifecare twice yearly to meet with residents.</p> <p>On interview, seven of seven residents confirm their understanding of their rights, and their comfort in raising in any concerns directly with the General Manager.</p>

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

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
Evidence: A privacy and dignity policy and procedure is available which clearly defines and states the privacy and dignity needs of the residents will be maintained at all times in line with the requirements of the Privacy Act 1993 and the Health and Disability Services Standards. Associated policies, such as the privacy and confidentiality policy, provides clear definitions of privacy and confidentiality and clear examples of how this can be maintained by staff and outlines staff responsibilities in relation to personal privacy, dignity and respect whilst providing cares and maintaining independence of residents. There is a comprehensive policy and procedure on maintaining culture, values and care and a policy for abuse and neglect which has clear definitions of what constitutes abuse and how staff can recognise and identify the signs and symptoms and how and who to report suspected abuse.

On interview, seven of seven residents, and two of two family members confirm that residents are treated with respect, and their dignity, privacy and independence is respected. Resident care-plans (nine of nine – seven rest home and two hospital level) demonstrate an individualised approach to care delivery, which also maintains residents' independence and promotes the maintenance of residents' self-abilities.

Interviews with care delivery staff (eight of eight) and the general manager demonstrate a strong commitment to treating resident with respect, and the maintenance of dignity, privacy and independence. Clear understanding is also demonstrated of what constitutes abuse and/or neglect; steps that should be taken to prevent this, and the steps to be taken should it occur.

During the audit staff were observed to talk to residents respectfully and knock on doors before entering. All residents have a spacious private room, and there is evidence of residents being encouraged to personalise their rooms.

Residents' care plans and other records are securely stored in locked cupboards or staff offices, and all electronic records are held on password protected computers.

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:

There is a comprehensive 'Maori Residents: Cultural, values and care' policy, which describes the expectations when providing care and services for residents who identify as Maori. Residents who identify as being Tangata Whenua are part of the obligation to Te Tiriti o Waitangi principles of partnership, participation and protection.

None of the current Molly Ryan residents identify as Maori, but there are staff who identify as Maori. A staff member is supported to attend a Whanau Ora training programme, and there are established links with local Maori, as well as Maori health services at the Taranaki District Health Board (TDHB).

Following an invitation from Tu Tama Wahine o Taranaki , a resident outing has been arranged for later this month (February) to visit Parihaka, a site of considerable significance to Maori.

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

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

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

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: Document Review: A range of policies, such as maintaining culture and values, guides care delivery practices. A care-plan review (seven of seven rest home, and two of two hospital-level) demonstrates the identification of individual ethnic, cultural and spiritual requirements, and interventions to ensure these are met. One resident, with specific cultural needs related to her ethnic identity, has a detailed care-plan which establishes her individual goals, and the interventions associated with those. For example, there is evidence of a range of initiatives undertaken by the service to ensure that her specific dietary requirements are met, including a review

by a registered dietician. The resident is also taken shopping twice weekly to select her food.

On interview, seven of seven residents and two family members report that culturally safe services are being delivered, and that they are consulted about their individual values and beliefs.

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: <p>Policy and procedures related to discrimination ensure residents receive services free from any discrimination, and that residents are not subjected to any form of coercion, harassment, sexual or other exploitation. The policy includes professional boundaries for staff and how they are to be maintained for the well-being of the residents.</p> <p>On interview, care delivery staff (seven of seven) demonstrate clear understanding of what is required to ensure residents are free from discrimination, how to maintain professional boundaries, and the processes that should be followed should any untoward events occur. The orientation/induction processes inform staff about resident rights, and job descriptions and employment agreements provide clear guidelines on how to observe professional boundaries.</p> <p>On interview, seven of seven residents and two of two family members confirm that residents do not experience any discrimination, and that service providers act professionally at all times. They also confirm their understanding of how to make a complaint, should this be necessary.</p>

On interview, the General Practitioner and the Physiotherapist confirm their satisfaction with the services provided to residents, and their confidence that residents are not discriminated against in any manner.

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

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

Consumers receive services of an appropriate standard.

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

Attainment and Risk: FA

Evidence:

Registered nurses are on duty 24 hours each day at Molly Ryan Lifecare, and are available to provide support and guidance to care delivery staff.

The service uses a range of resources provided by external consultants, such as wound care and infection control, to guide best practice. External consultants are also involved in ongoing staff education, such as health and safety, nutrition, and managing challenging behaviours. The service also maintains close links with specialist staff, such as wound care nurses and diabetes specialist, at the TDHB. All the registered nurses at the facility are engaged in the Professional Development Recognition Programme through the TDHB, and have access to a range of educational opportunities. Molly Ryan Lifecare also provides a detailed education programme for staff annually.

On interview, eight of eight care delivery staff (one registered nurse, one enrolled nurses and six caregivers) report they are actively encouraged and supported to further their knowledge and skills. Staff also report they have access to all the equipment, such as a range of wound care products, necessary to provide care of a high standard.

A multidisciplinary approach is taken to minimise/prevent resident falls. All residents are assessed by a physiotherapist at the time of admission, and further assessments are undertaken if a resident falls. Pendant alarms are given to residents at risk of falling, so that they can summon staff promptly as required. All falls are reported promptly (sighted in several residents' files) and falls rates are reviewed regularly by the quality committee.

Refer to criterion 1.3.3 that demonstrates best practice in wound management.

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: <p>Policy on open disclosure defines and clearly describes what open disclosure is, in order to guide staff. The policy states that open disclosure contributes to the foundation of a successful service provider relationship by ensuring trust, is a right of a resident under the Code and is part of the move towards increased accountability from staff. Open disclosure is required for the informed consent process, especially when there is a need for further treatment or care and is a demonstration of the philosophy of valuing residents and families as part of the team with a family centre approach to care delivery.</p> <p>On interview, seven of seven residents and two of two family members confirm their satisfaction with the communication they receive from service providers. A communication sheet in each of the nine resident files reviewed include details of all communication with families, and there is other evidence, such as incident forms, that demonstrate families are advised promptly of any concerns or untoward events. Residents and families also participate in the six-monthly multidisciplinary review of each resident.</p>

The Clinical Nurse Leader reports that if interpreter services are required, these can be accessed through the TDHB. There is an interpreter/translation policy available to guide staff on who to contact as required.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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 1.1.10: 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:

There is a clearly defined informed consent policy on the definition of informed consent and the obligation to provide appropriate information for residents/family/whānau to make informed choices and give informed consent when and if required. Policies are available for advance care approaches and cardiopulmonary resuscitation (CPR) outlining the expected standards.

Each of the nine residents' records reviewed contain a CPR form that had been developed in consultation with the resident and their family, and signed off by their general practitioner (GP), and an informed consent form, signed by the resident and/or their EPOA. The informed consent form includes storage of information, care and treatment, making choices, information being available to families, choosing a GP, and permission for taking a photograph of the resident, and for outings. These forms are reviewed and renewed annually.

On interview, seven of seven residents and two of two family members confirm that residents are actively involved in decision making processes, and are given the information that they require to make these decisions.

The Clinical Nurse Leader confirms on interview that at the time of admission residents are asked about their advance care wishes and these are incorporated into their plans.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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:

A consumer rights policy states information will be provided on admission and will be made available on advocacy and support services available.

Information on consumer rights and advocacy and support is provided to residents and their families as part of the admission information pack. Seven of seven residents and two of two family members confirm they received information on advocacy and support, and are aware how to access this should it be required. Each of these residents and the two family members also expressed their comfort with raising concerns with the Clinical Nurse Leader and/or General Manager if this was necessary.

A brochure on the Nationwide Health and Disability Advocacy Service is displayed at the reception area. An advocate from that service visits the facility twice yearly to meet with residents and to conduct a yearly in-service education sessions for staff. On interview staff confirm their understanding of the role of the Service, and how the Service can be contacted.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service strongly promotes residents to maintain links with their family/whanau and community.

The facility has its own mobility van, and this is in frequent use for resident outings, to support them to access community services, such as audiology, Medlab and ophthalmology services, plus twice-weekly shopping trips, and participation in community events. Community groups and entertainers also visit the facility on a regular basis.

There is open visiting at the facility, visitors are encouraged, and two of two family members report on interview that they are always made to feel welcome when they visit. Residents are also encouraged to go on outings with their families, and there is evidence of service flexibility to ensure the needs of individuals can be met in relation to this.

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: Documentation review: There is a comprehensive complaints and concerns policy. The policy describes the expectations of all aspects of identification and manages complaints and concerns and to make clear the philosophy underpinning Molly Ryan Lifecare Ltd that all complaints or concerns are reviewed as part of the continuous system improvement. Clear definitions of complaints are documented and the complaints procedure is clearly outlined from receipt of a complaint/concern to resolution. A complaints register was seen and all complaints are managed correctly. Staff interviewed are able to report on what actions they would take and the person they would speak to. Residents interviewed report that they have no complaints and would feel comfortable to speak to any staff or management.

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: Document review: The Business and Strategic Plan for 2013-2015 outlines the organisation’s mission, goals, targets, objectives and long term action plan. This was issued in September 2013 and next review date is set for September 2015. The business plan contains strengths, weakness, opportunity and threats (SWOT) and business analysis.

The service has a general manager/registered nurse with experience in the aged care/retirement village industry. The GM is also a shareholder and reports to the board of directors. She is responsible for all operational matters relating to the facility and overseeing the governance structures. There are four directors who meet four times a year and the GM sends a report every two months. To ensure her practising certificate is current she attends all relevant education available with the TDHB and attends conferences/seminars relating to the retirement village and the aged care association. The general manager is responsible for ensuring the overall financial welfare of the service. The sighted job description for the general manager describes the authority, accountability and responsibility for the overall financial management.

The general manager is supported by a full time Clinical Nurse leader (CNL) who is responsible for clinical service delivery at Molly Ryan. There are RNs on each duty and they are supported by on call management.

The relevant ARRC requirements are met.

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

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

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

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: <p>The clinical nurse leader (CNL) for Molly Ryan Lifecare takes on the management roles during temporary absences of the general manager. The CNL job description includes the requirements to take on the management duties in temporary absence of the general manager. The CNL reports that they have had suitable training to take on the general manager's role during temporary absences and feel that they are also well supported by TDHB if advice is required for clinical aspects of service delivery. The education records and personal files reviewed evidence ongoing education and professional development.</p> <p>The relevant ARRC requirements are met.</p>

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The risk management guidelines for 2013-2014 contain the organisation's objective in quality and risk management. The plan describes the organisation's commitment to continuous quality improvement. Each part of the service is audited internally, with findings communicated to staff through regular staff meetings.

The quality improvement and risk management guidelines identify objectives, action, planning and support to reach identified goals. The overall objective is to meet the needs of all the residents and enhance satisfaction with support/care services and all services they provide. The quality plan covers all aspects of service delivery with actions shown on how to minimise identified risks, who is responsible and the timeframe for implementation. The business risk management plan covers being a good provider, responsible planning, safe environment, and internal audits. The organisation has a quality and risk management system which is understood and implemented by staff; as confirmed at interview with the 15 of 15 staff.

The service develops and implements policies and procedures that are aligned with current good practice and service deliveries, meets the requirements of legislation, and are reviewed at regular intervals as defined by policy. Policies are reviewed at least two yearly, or sooner if there are legislative changes. Policies sighted are reflective of good practice and all policies are reviewed by the general manager and CNL. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff. The footer of each document contains the version control information.

Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. Internal audits sampled for 2013 include building maintenance, food safety, safe environment, infection control, organisational management, care services and waste management. Data is collected for all key performance requirements and analysed and evaluated monthly at the staff and management meetings (minutes sighted). The 15 of 15 staff interviewed report the quality improvement data, results from internal audits and areas of required improvement are reported back to them through the staff meeting and staff communication book/notice board.

Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective action request forms are documented and actioned as required to evidence the summary of the event, what has been learned, what actions were taken and why, and the outcome. The corrective actions analysis includes collation, review and actions implemented. A re-audit of the issue is conducted to review if the actions implemented are effective in minimising or eliminating the area of concern.

Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whanau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, and the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained by the GM/RN. The risk register is maintained for each area of the service including the independent living apartments. A list is located in each area of the service, for example, the kitchen and medication room. Manual handling and biological hazards, chemical hazards and contractors on site are all recorded.

The relevant ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The 15 of 15 staff interviewed demonstrate understanding of the requirements for adverse event reporting. The GM/RN has an understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The GM/RN reports that there have been no incidents that have required essential notification.</p> <p>The service documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. They are reviewed and analysed on a monthly basis. The adverse event forms are used for making improvements where required. The adverse event reports include a summary of the incident, immediate actions, corrective actions and outcomes. The follow up includes a re-audit of the implemented actions to review if the hazard has been controlled or eliminated.</p> <p>The relevant ARRC requirements are met.</p>

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

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

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

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 1.2.7: 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:

Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for the RNs, GPs, pharmacist and podiatrist.

There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The eight of the eight files reviewed (two RN, three caregivers, one cook, one activities coordinator and one maintenance) demonstrate appropriate recruitment and employment processes. The recruitment and employment process includes advertising, interview process, reference checking, police vetting and qualification validation. The GM/RN reports that potential staff are assessed to ensure they have the positive attributes to enable them to work with the residents. There is a performance appraisal system, which is conducted at least annually for all staff (confirmed in the eight of the eight staff files reviewed). The newer staffs also have a performance review after the first three months of employment.

New service providers receive an orientation/induction programme that covers the essential components of the service provided. The orientation consists of a checklist, orientation shifts (with includes all shifts), and a handbook with the services key policies and procedures. The orientation covers the services philosophy and vision, code of right, complaints management, staff requirements (eg, code of conduct), health and safety, basic care skills, infection prevention and control and food services. The orientation for all staff includes sessions on implementation of activities and the management of challenging behaviours. The eight of the eight staff files reviewed showed evidence of orientation and the 11 of 11 staff interviewed (two RN, six caregivers, one EN, one cleaner and one laundry) confirmed they received an orientation that was effective in preparing them to work in the service.

A system is in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The ongoing in-service plan for 2013 is sighted. The education provided in 2013 is appropriate for rest home and hospital care. The service provides support for the staff to complete the Aged Care Education (ACE) national qualifications and the dementia modules will be completed this year. Attendance records are maintained in the education folder and in each individual staff member's education record. Education conducted over 2013 includes; management of challenging behaviours (August 2013), infection control (October 2013), Consumer rights (July 2013), elder abuse and neglect prevention (November 2013), palliative care (April 2013). The education programme has specific topics in relation to care of the older person, such as skin care, documentation, manual handling, continence management, pressure are care, wound care, nutrition and communication. The education programme contains the essential and emergency requirements such as fire safety and civil defence response. All staff have a current first aid qualification as confirmed at interview with the general manager and 11 of 11 staff interviewed. Sighted in the eight of eight staff files reviewed.

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>There is a clearly documented and implemented process which determines staffing levels and skill mixes in order to provide safe service delivery and the layout of the service. The rest home, hospital and independent apartment are all in the same building. The GM/ RN reports that care staff can deliver services to the independent living apartments if required.</p> <p>The GM/RN is on site Monday to Friday and is on call when offsite. The CNL provides support and direction to the RNs and shares on call with the GM/RN. There is a new graduate RN and she reports on interview that she is supported by CNL and is enjoying her role. The RNs attend in service education provided by the TDHB as available.</p> <p>The diversional therapist completed her qualifications in 2012.. She demonstrates knowledge and skills in assessment, implementation and evaluation of diversional and recreational programme. The GM/RN reports that the staff are working towards the dementia unit standards this year.</p> <p>On review of the roster there is evidence of sufficient staff to ensure safe staffing levels on all shifts over 24 hours a day and seven days a week (24/7) days.</p> <p>The seven of seven residents and two of two family/whanau report satisfaction with the skills of the staff and the care provided. The family satisfaction survey from July 2013 has comments such as 'impressed and touched by the support offered' and 'the care is beyond our expectations'.</p> <p>The relevant ARRC requirements are met.</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>A range of strategies and processes ensure that resident information is managed in an appropriate manner. Several specific software programmes are utilised to ensure the safety and security of resident information, and all electronic information is backed up using the 'Cloud' and backup tapes.</p> <p>All resident-related electronic information is password protected, with staff having different levels of access to this information, depending on their roles. The positioning and location of all the computer screens throughout the facility means they cannot be viewed by anyone other than staff members.</p> <p>Each resident record reviewed (nine of nine) includes the unique NHI number for that resident on all pieces of documentation. Resident-related information not in current use is stored in a locked cupboard, and is easily retrievable.</p> <p>Hard-copy information, such as the resident's care-plan folder, is stored in the nurses station room, which has a keypad entry. During the audit, it was observed that this office was always locked when unattended.</p> <p>Resident progress notes are updated every shift, and there is evidence of consistent, thorough and legible documentation related to resident assessment, care planning, and evaluation of care. Resident notes are integrated, and well-organised within their individual folders, meaning information is easily located.</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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

All records pertaining to individual consumer service delivery are integrated.

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:

Documentation Review: The organisation has a clearly identified process for pre-entry and entry to this service. The requirements for all residents to be assessed prior to admission or transfer to another service is made known to staff. The information pack is provided and pre-entry and entry requirements are highlighted. Entry to all services is facilitated in a competent, suitable and respectful manner.

The Clinical Nurse Leader reports that all resident must have been assessed by the NASC Service (Taranaki Community Support Services) prior to admission. In nine of nine resident records reviewed there is evidence of such an assessment having been undertaken prior to admission, and the level of care required by the resident is clearly established and documented.

The Admission Agreement complies with the requirements of the ARC contract, and includes information on the management of 'difficult' residents when a subsidised resident can be removed from the facility. Two of two family members interviewed confirm their satisfaction with the information provided to them during the admission process of their family member.

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

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

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

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The General Manager outlines the processes that have been followed when entry to the service has been declined. This includes working with families and the GP, the Taranaki Community Support Services, and ensuring family understanding of the appropriate assessment services to be completed.

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:

Experienced registered nurses undertake all stages of service provision in relation to assessment, planning, evaluation and review of residents. A range of information is used as the basis for the initial assessments, including the interRAI assessment, hospital discharge letters, and information provided by the resident and their family and whānau. All residents are reviewed by a general practitioner within two working days of admission (confirmed in nine of nine resident files), and residents are able to choose which GP will provide their medical care.

Nine of nine resident files (two hospital-level, seven rest home) demonstrate that each stage of service provisions has been undertaken by suitably qualified providers, within the timeframes set down in the Aged Residential Care (ARC) contract - all short-term care plans are developed within 48 hours of admission, long-term care-plans within three weeks of admission, and care plans are evaluated at least six monthly, and earlier if residents' needs change.

Registered nurses are also on duty seven days a week, 24 hours a day, to lead and provide oversight of the provision of resident care. Coordination of service delivery is managed in a number of ways. There is a verbal handover meeting at the start of each shift; a manager's report, which includes any changes to resident care/status, is available both electronically and in hard copy; and all care-giving must sign that they have read the communication diary at the start of each shift. A colour-coded list of resident allocations, linked to the staffing roster, ensures that the responsibilities of specific caregivers each shift are clearly outlined.

On interview, a general practitioner confirmed his satisfaction with the services provided to residents at Molly Ryan Lifecare, and that he is contacted promptly when there are any concerns about a resident.

Tracer One.

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

Tracer Two.

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

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

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

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 1.3.4: 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 facility is current in the process of introducing interRAI assessments for all residents. At the time of audit, four staff have completed the interRAI training, and 21 of the 34 residents have been assessed. The findings of these assessments inform the care-planning process, using the facility' own care-plan format. A quality project is planned for the near future to review the care-plan format, and realign this to the interRAI process.

There is evidence of comprehensive and ongoing resident assessment in all of the nine care-plans reviewed, such as falls risk and pressure area risk, nutrition and hydration, oral health, pain, activities of daily living, sexuality, values and beliefs.

Residents also complete a problem/issues and goals assessment form on an annual and as-required basis. This identifies what residents see as their main problem, and their long-term goals related to this.

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

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

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

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

Attainment and Risk: FA

Evidence:

All of the nine care plans reviewed demonstrate a focus on addressing resident's identified needs, with clear interventions detailing the services to be provided. There is evidence of integration of treatment prescriptions/recommendations from other health professionals, such as dietitians and physiotherapists, in the resident's care-plan.

Short-term problems and interventions are recorded on a short-term care plan form or problem record, and evaluated regularly. A full evaluation of the long-term care plan occurs six monthly and as required (eight of eight care plans), and a multidisciplinary review of each resident is undertaken six monthly. Informed consent and resuscitation status are reviewed and renewed annually.

Seven of seven residents and two of two family members confirm on interview their involvement in and satisfaction with the service delivery process.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>A comprehensive care plan format provides detailed guidance for care delivery staff to enable achievement of resident goals. All of the nine care-plans reviewed demonstrate evidence of regular evaluation and review (at least six monthly) and on an as-required basis when resident needs change. A multidisciplinary review is undertaken for each resident every six months.</p> <p>Seven of seven residents confirm on interview that their needs and desired outcomes are being met, and their satisfaction with the services provided to them.</p> <p>On interview a general practitioner and a physiotherapist state their high regard for the standards of care delivery services at Molly Ryan Lifecare.</p>

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: 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 1.3.7: 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: <p>An experienced diversional therapist, who is currently undertaking the diversional therapy training, oversees the activities programme at Molly Ryan for 30 hours each week.</p> <p>Each resident completes an activities and social history assessment within two weeks of admission to the facility, and a plan of care is developed in consultation with them and their family. The plan is evaluated six monthly (observed in eight of eight resident records), and a daily record is kept of participation in activities. The wishes of residents who do not want to participate in activities is respected, and they are offered one-on-one activities.</p> <p>An activities programme is published weekly. A wide range of activities are offered, including newspaper reading, two shopping trips using the facility van each week, weekly outings, games, quizzes, guest entertainers, bowls, movies, happy hour, and housie. Residents are encouraged to maintain their physical health with exercise sessions and/or walking trains each week day. Three times each month church services are held at the facility. Special events, such as holidays and other celebrations are also marked.</p> <p>All residents interviewed (seven of seven) express their satisfaction with the activities on offer at Molly Ryan Lifecare.</p>

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: All of the nine care delivery plans reviewed for this audit demonstrate comprehensive evaluation at least six monthly and earlier when clinically indicated. The Clinical Nurse Leader takes overall responsibility for ensuring that progress towards achieving care goals is evaluated, documented, and care plans are updated where appropriate. Colour coding used in the care-plan format means that the evaluation of goals is readily identifiable. Four of four residents confirm their involvement in care plan evaluations, and one of one family member confirms she is informed of any change in the resident's needs. There is evidence of ongoing assessment when care goals are not being achieved and adjustment of care delivery plans.

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

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>Each new resident is able to choose which GP will provide their medical care. If a resident is new to an area they are supported to enrol in a GP practice. GPs visit on an as-required basis, and/or residents are taken to the GP surgeries for consultations.</p> <p>Three of three resident records reviewed demonstrate their referral to other health service providers, such as audiology clinics, and dentists. Transport is provided for resident to access these services. Four of four residents, and one of one family members confirms they are involved in, and kept informed about, referral processes.</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: When residents transfer from Molly Ryan Lifecare to other health care services a comprehensive TDHB rest home transfer form is completed (completed forms sighted in the files of two residents had been transferred to the public hospital). In addition, copies of their cardiopulmonary resuscitation form, their medication chart and administration record, and their most recent GP consultation record, are also attached to the form, together with family contact details.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review: There are clearly documented policies and procedures documented and implemented for medication management. There is a separate medication manual available accessible in hard copy and electronically for all staff. All policies have been reviewed and are up to date. The pharmacy service is outlined clearly and all approved abbreviations are documented. The medication management system policies and procedures are numbered and indexed appropriately that cover all aspects of medication management inclusive of guidelines and legislative requirements being clearly referenced and met. A medication management policy is documented and refers to the processes to be used to prescribe, dispense, administer, review, store, and dispose of medications.

The medication management systems complies with legislation, protocols and guidelines. The Packette sachet medication system is used for all regular medications, with pro-ra-nata (PRN) medications provided in blister packs. Only registered or enrolled nurses undertake medication administration. Their medication competency is assessed annually (records sighted). No stock medications are held in the facility, and when there are changes to any medications these are collected on an as-required basis from the pharmacy.

There is evidence of a robust stock reconciliation system, including registered nurse checking of all Packette medication on delivery, and weekly reconciliation of controlled medications. Surplus and expired medication is placed in the Returns Bin prior to return to the pharmacy.

All of the fourteen medication charts (two hospital-level and twelve rest home) reviewed demonstrate compliance with all legislative requirements.

An observation of a medication round confirms best practice in medication administration, including checking the medication prescription with the medication in the Packette, confirming the identity of the resident using the photograph in the medication chart, verbal checking prior to administration, and the timely documentation of medication administration.

All eye drops and inhalers are replaced monthly, and all medications in the medication trolley are within current use-by dates.

There is evidence of robust processes associated with the documentation and management of medication errors, and daily checking of the medication fridge temperatures.

Two residents are currently self-medicating. There is evidence of compliance with the policy on self-medication, including three-monthly RN assessment, and GP sign-off, and ongoing checking of compliance with the medication regime. One of these residents was interviewed and demonstrated understanding of her role, knowledge about medications she is taking, and the locked container in which her medications are stored.

An annual review of the medicine management programme is completed by an external consultant in January 2014.

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

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

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

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:

The food service policies and procedures are available and implemented. Guidelines are used that provide nutritious and appropriate meals for aged residents.

A four-week menu cycle is in place and all residents interviewed (seven of seven) express their satisfaction with, and enjoyment of, the meals provided to them. All residents have breakfast in their rooms, and are encouraged to come to the spacious and attractively furnished dining room for lunch. Wine is offered to residents with their midday meal.

On admission, all new residents complete a dietary assessment form which includes their preferences and dislikes. A copy of this form is kept in the kitchen, and details of individual preferences and dietary needs are also recorded on the kitchen whiteboard.

Residents are weighed monthly (sighted in all resident records reviewed), and referrals are made to the dietician when residents experience weight gain or loss, or have special nutritional needs. Percutaneous endoscopic gastrostomy feeding is being provided to one resident, and detailed TDHB guidelines on her nutritional management are available as a resource for staff.

An experienced and qualified acting food services manager is overseeing meal provision at Molly Ryan. All staff working in the kitchen have completed food safety training (NZQA167).

On inspection, the kitchen is noted to be clean, well-organised and well maintained. All items in the fridges and freezers are covered and dated; there is evidence of stock rotation; and food is stored appropriately. There is evidence of a rigorous cleaning schedule, and records are sighted of completed cleaning and equipment servicing. Ecolab is responsible for dishwasher servicing and monitoring, bain-marie temperature, and cleaning chemicals. Fridge and freezer temperatures are recorded on a daily basis and are maintained within the required range. Kitchen waste is either disposed of through an insinkerator, or in a large hooker bin which is emptied weekly.

The kitchen is able to accommodate a range of dietary needs, including diabetic, gluten-free, vegetarian diets, and puréed/moulied food. A range of specialised equipment, such as lip plates and feeding cups, are available.

A New Zealand registered dietician reviews the menu every two years (most recent reviewed 27 May 2013).

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

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

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

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:

Document review: The management of waste and hazardous substances policy complies with the requirements of the standard.

The laundry has a dirty to clean flow. Protective equipment and clothing (PPE) appropriate to the risks involved when handling waste or hazardous substances is provided and used by the housekeeping staff. The housekeeping supervisor reports that they have had recent education in protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances (last conducted May 2013). Waste management is part of orientation and the external chemical supplier conducts ongoing education through an 'On Line' education package.

The ARRC requirements are met.

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>Documentation Review: The organisation has a policy in place in relation to transportation of residents. The building warrant of fitness expires in 15.02.15.</p> <p>All buildings, plant, and equipment comply with legislation. The electrical test and tag was conducted January 2014. The medical equipment calibration was last conducted November 2013. The equipment calibration includes the blood pressure monitors, thermometers and hoists.</p> <p>The hot water temperatures are checked in resident areas monthly. The temperatures are all within required limits.</p> <p>There is a planned and ongoing maintenance plan (sighted). The long term maintenance covers a schedule until 2025 (sighted).</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents at rest home and hospital level of care.</p> <p>Residents are provided with safe and accessible external areas that meet their needs. All rooms in the rest home and hospital have access to outside either directly or by lift if on the second floor. There is adequate outside sitting area with shelter as required.</p> <p>All rooms are suitable for either hospital or rest home level care. The five apartments viewed are suitable for rest home or hospital level care.</p>

The relevant ARRC requirements are met.

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 rooms are built with an ensuite which is designed for both rest home and hospital level care. There is a toilet available for residents use in the communal areas to ensure they do not need to return to their room. There is one visitor toilet on each floor with adequate signage. The relevant ARRC requirements are met.

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

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

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

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

Attainment and Risk: FA
Evidence: The rest home and hospital rooms are all single with a full ensuite. They are of adequate size to enable a hoist to be used if care requirements increase. They are able to have seating for visitors and space for personal items. The ARRC requirements are met.

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Both the rest home and hospital residents are provided with safe, adequate, age appropriate areas for relaxation, activities and dining. The facility has an open plan lounge and dining area that is furnished with attractive settings. There is also external seating and grounds for setting, dining and relaxation. All rooms on ground floor have direct access to the external areas. A range of activities are provided every day by care staff. These include outings, activities of daily living, creative and physical play and pet therapy (observed on day of audit and confirmed by relative and staff interview). The recreation and dining areas are safe and adequate for use by older person with cognitive impairment or falls risk.

The ARRC requirements are met.

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

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

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

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

Attainment and Risk: FA

Evidence:

Document review: The cleaning and laundry service manual 2013 sighted complies with the requirements of the standard.

The chemicals are stored in the cleaner's room. There are locks on the door to the cleaning room to provide secure storage. When the cleaning trolleys are not in use, these are stored in the cleaner's room.

The cleaning and laundry equipment and chemicals are monitored monthly by the external chemical supplier. The seven of the seven residents and two of two family/whanau report satisfaction with the cleaning and laundry services.

All chemicals sighted are adequately labelled with the suppliers labels.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: <p>Documentation Review: The organisation has a documented emergency and disaster plan in place as per the Health and Safety programme.</p> <p>Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The fire drill was conducted in November 2013 for the rest home and hospital. The earthquake and fire emergency training was last conducted in September 2013.</p> <p>Both the rest home and hospital have a civil defence kit, with adequate food and water for a minimum of three days. The service has a generator, which automatically comes on during power outages. There are adequate torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly by an externally contracted fire safety consultant and these are carried out at different times of the day (records of last fire drill October 2013 on areas of both the rest home and hospital. These trial evacuations are used for monitoring a safe/secure environment and reviewing any adverse events (as confirmed at interview with staff and the general manager).</p> <p>The rest home has a call bell system in all resident areas. There is an audible alert and a light above the room where the call bell is activated. The seven of seven residents report a timely response to the call bells.</p> <p>The ARRC requirements are met.</p>

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

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

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

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

The internal temperature is monitored monthly. The facility has central heating in the common areas by air-conditioning/heat pump units, with each room having individual heating. Each room has adequate lighting and windows to allow for natural light and ventilation. Heat pumps/air-conditioning units are used in the common areas for heating and cooling. All lounge and common areas have at least one window/door for natural light and ventilation. The seven of the seven rest home residents and two of the two family/whanau report satisfaction with the light and ventilation.

The ARRC requirements are met.

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

Evidence:

Document review: The restraint minimisation and safe practice policies comply with the requirements of the standard.

There is no recorded restraint or enabler use at the service, and this is confirmed at interview with the GM/RN, RNs and caregivers. The restraint register has no recorded restraint or enabler use. As sighted in the service policy, if enablers are to be used, they shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety.

Staff training in restraint minimisation (August 2013) and strategies for managing challenging behaviour, understanding delirium, confusion and dementia are frequent in-service education topics. Training records show education provided by the CNL and external presenters, last conducted in August 2013. The six of six caregivers interviewed demonstrate knowledge on restraint and enabler use and the minimisation of challenging behaviours.

The ARRC requirements are met.

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

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

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: A robust infection control management system at Molly Ryan Lifecare minimises the risk of infection to residents, staff and visitors, and is consistent with regulatory requirements and best practice. In October 2013 the facility experienced an outbreak of norovirus, which was quickly contained. However, as a result of that experience, considerable work has been undertaken to strengthen processes associated with infection control management. These include the introduction of a four-person infection control committee (the General Manager, an enrolled nurse, the human resources administrator, and chaired by a registered nurse), external training for registered nurses, a two hour education session run by an external consultant for all staff, the introduction of terminal room cleaning of a resident's room when they come out of isolation, and the contents of three outbreak boxes have been reviewed.

Infection control management is guided by the use of an external aged care consultant service, and support and advice is also available from the Infection Control team at the TDHB when required. An external consultant has just completed (January 2014) an annual review of infection control management.

Infection control matters, including surveillance results, are reported monthly to the Quality Committee (infection control is a standing agenda item), and then to the Board of Directors by the General Manager. Infection control issues, including surveillance results, are shared with staff via meeting minutes, as a standing agenda item at staff meetings, and in resident newsletters.

On interview, staff (fourteen of fourteen) confirm the understanding of the requirement to stay away from work if they have the flu/heavy cold or any other infection that might be a risk to others, and for at least 48 hours following any gastrointestinal upset. A large sign at the main entrance to the facility asks anyone who is, or who has been unwell in the past 48 hours, to refrain from entering the facility.

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

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

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: Documentation Review: The infection control committee consists of a broad cross section of staff with varying specialist skills and expertise. The terms of reference identifies that the infection control committee facilitates the implementation of the infection control programme. The infection control team have the appropriate skills, knowledge and experience for their role. The General Manager has previously completed infection control management training, and following the norovirus outbreak all registered nurses completed external infection control training. The team have well-established networks with the Infection Control team at the TDHB and can access additional information and support as required. The General Manager and Clinical Nurse Leader confirm there are enough human, physical and information resources to implement the infection control programme. On interview staff (fourteen of fourteen) confirm that they have ready access to a range of physical resources, such as hand sanitisers and protective personal equipment,

and are aware of infection control principles and how to implement these. There are hand sanitiser dispensers in each resident's room and at numerous locations around the facility. Anyone entering the facility is asked to sanitise their hands before entering.

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

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

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

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

Attainment and Risk: FA

Evidence:

Documentation Review: Policies and procedures comply with relevant legislation and current accepted good practice. Policies and procedures sighted cover all requirements to meet this standard. Policies and procedures are consistent with infection control principles. Review is part of the terms of reference for the infection control committee to be overseen by the infection control nurse/co-ordinator/NM.

The infection prevention and control policies and procedures are developed by an aged care consultant. These comply with accepted best practice and relevant legislation and are reviewed on an annual basis (last reviewed January 2014). Several educational resources associated with these policies and procedures are displayed in the nursing station.

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: <p>A range of education sessions related to infection control management are regularly offered to staff. The General Manager and the Clinical Nurse Leader provide in-service education and external consultants are also utilised for education sessions.</p> <p>All staff are required to attend infection control and isolation training on an annual basis and additional sessions on an as-required basis, such as during an infection outbreak or increase in resident infection rates. On interview, staff confirm their satisfaction with the infection control education provided to them, their understanding of infection control principles and how to prevent/minimise infection. For example, the housekeeper outlines the training she has received, the appropriateness of the supplies available for her use, the stocking of the isolation trolleys, and the communication related to infection control processes.</p> <p>Information for residents is included in the resident newsletters, and education sessions are provided on an as-required basis, such as during an infection outbreak.</p>

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

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

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:

A range of surveillance activities are undertaken at Molly Ryan Lifecare and are appropriate to the size of the facility. Data is collected on antibiotic use, wound infection, gastric infections, chest infections, urinary tract infections. The relationship between being placed in isolation because of infection and increased falls risk is also monitored.

Random testing of staff hand hygiene, using 'glow sticks' is proving an effective educational strategy, which has resulted in more effective hand washing practices.

A monthly analysis of the type and incidence of infections is presented to the Quality Committee. Surveillance monitoring results are shared with staff through staff meetings, at daily handovers, and graphed surveillance results are posted in the nurses' station.

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