

Beckenham Courts Retirement Village Limited

Current Status: 21 March 2014

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

General overview

Ryman Healthcare are the proprietors of Beckenham Courts retirement village, situated in Christchurch. The facility is managed by a registered nurse who reports to a regional manager and operations manager. The service is certified to provide rest home level care for up to 88 residents. This is currently not possible due to earthquake damage and subsequent demolition and rebuild projects currently in place.

As a result, Beckenham Courts has reduced the care and services provided by 50 beds. There is currently an 18-bed rest home unit with full occupancy, and 20 of 32 serviced apartments which are able to provide rest home level care. Currently in the serviced apartments there are 11 residents assessed as requiring rest home level care, including two respite residents.

The service has made temporary changes to the physical environment during the rebuild including rest home dining room, office space, and laundry and kitchen facilities. The building site, adjacent to the rest home and serviced apartments, is secure and not accessible to residents or staff.

Beckenham Courts continues to implement a system of continuous quality improvement and residents and family spoken to advise that the staff are caring and attentive. The service has addressed all six of the shortfalls from the previous certification audit. These relate to aspects of care planning, medication documentation, progress notes and environment renovations.

This audit identified no improvements required.

Audit Summary as at 21 March 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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 21 March 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 21 March 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 21 March 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 21 March 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 21 March 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 21 March 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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HealthCERT Aged Residential Care Audit Report (version 4.0)

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:	Beckenham Courts Retirement Village Limited
Certificate name:	Beckenham Courts Retirement Village Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Beckenham Courts Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 March 2014 End date: 21 March 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:	29

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	5
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	11	Total audit hours	27
Number of residents interviewed	7	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	32	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Monday, 28 April 2014

Executive Summary of Audit

General Overview

Ryman Healthcare are the proprietors of Beckenham Courts retirement village, situated in Christchurch. The facility is managed by a registered nurse (RN) who reports to a regional manager and operations manager. The service is certified to provide rest home level care for up to 88 residents. This is currently not possible due to earthquake damage and subsequent demolition and rebuild projects currently in place.

As a result, Beckenham Courts has reduced the care and services provided by 50 beds. There is currently an 18-bed rest home unit with full occupancy, and 20 of 32 serviced apartments which are able to provide rest home level care. Currently in the serviced apartments there are 11 residents assessed as requiring rest home level care, including two respite residents.

The service has made temporary changes to the physical environment during the rebuild including rest home dining room, office space, and laundry and kitchen facilities. The building site, adjacent to the rest home and serviced apartments, is secure and not accessible to residents or staff.

Beckenham Courts continues to implement a system of continuous quality improvement and residents and family spoken to advise that the staff are caring and attentive. The service has addressed all six of the shortfalls from the previous certification audit. These relate to aspects of care planning, medication documentation, progress notes and environment renovations.

This audit identified no improvements required.

Outcome 1.1: Consumer Rights

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion were viewed in reception area of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet.

Outcome 1.2: Organisational Management

Beckenham Courts retirement village has a current organisational business plan and a facility quality plan to support quality and risk management. Quality information is gathered from internal audits, incidents and accidents, feedback from residents, family and staff. Data is collected and collated to provide opportunities for improvement. Resident/relative surveys are undertaken annually. Staff requirements are determined using an organisation service level/skill mix process and documented. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents, the service has a documented training plan.

Outcome 1.3: Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission using assessment tools. There are entry and

admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Support plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing support plans. Support plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. The service has addressed and monitored previous shortfalls relating to updating care plans, writing of progress notes, detailing care plans, and wound assessment and treatment plans.

Activities are provided in line with resident abilities and interests.

The medication management system includes policy and procedures that follows recognised standards. The service has addressed and monitored a previous finding relating to weekly checks of controlled drugs. Caregivers responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents' general practitioner at least three monthly.

The service has food policies/procedures for food services and menu planning appropriate for this type of service. Dietitian input is obtained if required. Residents' food preferences are identified and this includes any particular dietary preferences or needs.

Outcome 1.4: Safe and Appropriate Environment

The service displays a current building warrant of fitness. Previous audit shortfall identified around fixtures and floor coverings has been addressed.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. The service is restraint free and there are no residents assessed as requiring enablers. There is a restraint register and an enabler's register, restraint minimisation and challenging behaviour education has been provided.

Outcome 3: Infection Prevention and Control

The infection control nurse at Beckenham Courts completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	18	0	0	0	0	0
Criteria	0	41	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	32
Criteria	0	0	0	0	0	0	0	60

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 1.1.9: 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:

Ryman healthcare has an open disclosure policy with information included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or the registered nurse and a copy of any incident relating to individual residents is included in the clinical file. Progress notes records that families are informed following general practitioner (GP) review, incidents or accidents or if there is a change in resident condition (confirmed by three relatives interviewed). Notification of next of kin was recorded on the incident reports sampled. Copies of completed admission agreements are held in the manager's office and an extensive admission booklet is given to all new residents and/or family. There is an interpreter policy in place with information included in the admission booklet.

Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet. Residents (seven) and relatives (three) interviewed, confirmed they are kept fully informed. The admission booklet is available in large print and can be read to residents if 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.13: 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:

The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for 2013 and 2014 was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. The nurse manager maintains the records of all complaints that are processed as evidenced by the six complaints received for 2013 and one for 2014. Details of the management of the complaints is recorded including meetings with residents and family, letters of follow up and outcomes. Complaints are discussed at the Ryman Accreditation Programme (RAP) quality meetings and the monthly full facility staff meetings.

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

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:

Ryman Healthcare are the proprietors of Beckenham Courts retirement village in Christchurch. Ryman healthcare has robust quality and risk management programmes which are monitored closely by the organisation's head office. The nurse manager meets with a regional manager (RN) and an operations manager as required and provides a weekly management report to the regional manager on areas of occupancy, complaints, staffing and maintenance. The nurse manager also provides a monthly Ryman Accreditation Programme (RAP) return, on progress of quality plan goals and objectives. The nurse manager has been in the role for over seven years and has previous experience in retirement village management. The nurse manager is supported by the regional manager, a registered nurse and care staff. The service has an organisational strategic plan, and a current quality and risk management plan (RAP) for 2014. A quality management system is implemented which includes gathering data and information to provide opportunities for quality improvement. Each Ryman manager is provided with management training and support within the management development programme. The nurse manager maintains an annual practicing certificate and attends professional development and clinical education each year. The nurse manager has attended in excess of eight hours of professional development in the past 12 months including the Ryman manager's conference, seminars on human resource management and managing adverse events.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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: <p>Beckenham Courts retirement village is part of the wider Ryman healthcare group, which has a well-established quality and risk management programme in place. The Ryman accreditation programme (RAP) includes all quality and risk management objectives and goals to ensure that quality activities generate improvements in service. The current objectives for Beckenham Courts include successful transition to the rebuilt facility including communication with residents, relatives and staff; human resource management including recruitment of new staff; management of hazards and risk relating to the on-site construction work; and clinical objectives including reducing falls rates. Other objectives include quality improvement activities, monitoring performance and maintaining effective communication. Quality improvements for Beckenham Courts have also been documented and are developed as a result of feedback from residents and staff, audits, complaints and incidents and accidents. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the rebuild, current facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. Progress with the RAP is monitored through the monthly reports provided to the regional manager, monthly RAP committee meetings at Beckenham courts, and monthly full staff meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, wounds, complaints, and health and safety. The RAP committee meeting agenda includes (but is not limited to): previous meetings minutes, quality objectives review and progress, maintenance, education, meetings reports, audits, activities, infection control, health and safety, staffing, complaints and policies and procedures. Minutes are maintained (sighted for 11 February 2014). The full facility staff meeting agenda includes discussion on quality goals, maintenance, health and safety activities, resident satisfaction survey, audits, complaints, incidents and accidents, infections and education. Minutes are maintained (sighted for 20 February 2014) and staff have access to these meeting minutes in the nurses' station (confirmed by three care givers at interview). Further meetings are held for activities staff, health and safety/infection control, care givers, food service staff, gardening and maintenance, restraint and housekeeping. Minutes for all meetings include actions to achieve compliance where relevant. This, together with staff training, demonstrates Beckenham Courts commitment to on-going quality improvement. Resident/relative meetings take place bi-monthly with</p>

laundry, activities and food/meals as regular agenda items.

There is an internal audit schedule. It includes (but is not limited to): fire drill, hand washing, waste management, food temperatures, environment, laundry, housekeeping, health and safety, kitchen hygiene, residents' rights, medications, and care plans. A facility internal audit (last conducted in September 2013) is completed against the health and disability service standards with corrective actions developed according to risk.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the resident care plans. Policies and procedures are developed at organisational level with input from managers. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

There are procedures to guide staff in managing clinical and non-clinical emergencies and implemented risk management, health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by caregivers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the registered nurse and nurse manager who completes any additional follow up. The nurse manager collates and analyses data to identify trends. Results are discussed with staff through the monthly RAP quality meetings, and monthly staff meetings. Internal Audits for 2013 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey (May 2013) and a family survey (September 2013) is conducted annually. The surveys evidence that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via the facility newsletter. Corrective actions are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at the monthly RAP quality committee meetings, at health and safety meetings, and monthly general staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and three family member interviewed stated they are informed of changes in health status and incidents/accidents. A sample of ten incidents for January 2014 for four residents (one with two falls, one with skin tears and one with wandering behaviours) were reviewed. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the nurse manager. Referral to general practitioner and needs assessment team has been instigated as required. Medication errors are also reported. A monthly accident and incident review and summary is compiled by the nurse manager with subsequent analysis and investigations. Incidents and accidents are reported in progress notes and communication with family regarding incidents is also recorded. Staff have received education regarding incident reporting, conducting resident observations and communication with families in March 2014.</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: <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, and general practitioners is kept. There are comprehensive Ryman human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one registered nurse, two caregivers, one caregiver/activities coordinator and one serviced apartment coordinator caregiver). Advised that two reference checks are completed before employment is offered as evidenced in one recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There are specific induction modules for each role. Each new employee completes a general induction module with additional modules relevant to the specific role, for example, registered nurse role, cook, restraint coordinator, infection control nurse and cook. Three caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in five of five staff files reviewed.</p> <p>Discussion with the facility manager, and three caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and a plan for 2014. The annual training programme exceeds eight hours annually. Caregivers have completed either the national certificate in care of the elderly or are working towards completion of the ACE training programme. The nurse manager and registered nurse attend external training provided by Ryman including conferences, seminars and a three monthly journal club for registered nurses. The journal club is a peer review meeting with registered nurses from two other Ryman facilities in Christchurch. Discussion and peer review around a variety of clinical issues is conducted. Journal club for January covered clinical issues relating to palliative care, professional boundaries and code of conduct, informed consent, advanced care planning, infections, wound management and restraint. The nurse manager attends the Ryman annual conference and seminars.</p> <p>Education provided in 2013 includes but not limited to: continence, quality programme, cultural safety and spirituality, infection control, safe food handling, behaviour management, falls prevention, first aid, pain management, medications, code of consumer rights, restraint, safe chemical handling, and care planning. Fire evacuation</p>

drill last conducted 11 November 2013. Annual appraisals are conducted for all staff as evidenced in five of five 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Criterion 1.2.7.4 (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:

There is a documented staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home residents and residents in the serviced apartments. A minimum of two staff are rostered on at any one time with either the registered nurse or nurse manager providing on-call after hours and weekends. Roster includes: nurse manager 40 hours per week and one registered nurse for 40 hours per week. There are five caregivers rostered on in the morning – two in the rest home and three in the serviced apartment area working a mixture of short and long shifts. In the afternoon, there are two care givers in the rest home and two in the serviced apartments. Overnight there is one caregiver on in the rest home and one in the serviced apartments. The service also employs cleaning and laundry staff, cooks, activities staff and a maintenance person/gardener. Interviews with three caregivers, seven residents and two family members identify that staffing is adequate to meet the needs of residents.

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.3: 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; D16.5c; 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:

Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitable qualified staff that are competent to perform their role. Six of six resident`s files reviewed confirm that the registered nurse (RN) conducts the initial assessment and the initial care plan on admission to the service and in five of six files reviewed, develops the long term care plan within three weeks (one respite resident). Six of six care plans evidence a RN signature and date. Annual practicing certificates are sighted for all staff that requires them.

The initial and on-going assessments include cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, activities of daily living, skin/wound care, pain , dietary profile/diabetes management, social/spiritual/cultural and sexuality, activities and interests. The additional assessment tools include falls risk, pain chart, continence, nutrition, pressure area and challenging behaviour. The assessment tools are updated six monthly or as the residents` health care needs change. Five of six files evidence that any updates to the care plans are done and signed by a RN. The previous audit finding related to updates to care plans has now been addressed and monitored. Five of six (one respite resident) resident`s files evidence that the long term care plan is based on the assessed needs of the residents. The on-going long term care plan is recorded on a standardised template that is individualised to the resident`s needs. The care plan identifies the need, measurable goals that promote independence, assistance required, interventions and special instructions. The on-going care plan evaluation is conducted at least six monthly and is used to form part of the multidisciplinary review. The one respite resident`s file evidence assessment tools and an initial care plan completed by a RN, dated and signed within 24 hours of admission.

The six of six resident`s files evidence the initial medical review is conducted within two days of admission (where required). On-going medical reviews are conducted at least three monthly or more frequently if required. The service is co-ordinated in a manner that promotes continuity of care. Progress notes are comprehensive, updated daily by care givers or the registered nurse; and captures any change in the residents` health care needs (confirmed in the six of six resident`s files reviewed). Six of the six files evidence progress notes are dated and signed by staff entering the progress notes. The previous audit finding relating to progress notes has now been addressed and monitored. A handover is provided at the start of each shift, the three of three caregivers interviewed report that adequate information is provided at the verbal handover, written handover sheet and in residents` progress notes.

Seven of seven residents and three family/whanau report residents receive care that meets their needs. The residents and family members interviewed all commented that they are regularly consulted and invited to be involved in the care plan review.

Tracer example: Rest home resident

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

ARCC requirements are met.

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

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

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

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 1.3.5: 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
<p>Evidence:</p> <p>Previous audit identified improvement was required in relation to the level of care described in lifestyle support plans to meet the identified goals. In five resident files reviewed there is a long term comprehensive support plan and a daily support care plan implemented for all areas of care needs based on the interRAI assessment completed. Lifestyle support plans demonstrate service integration. Resident files include lifestyle support plans, short term care planning, notes by GP and allied health professionals, significant events, communication with families and notes as required by a registered nurse. This previously identified shortfall has been addressed and monitored.</p> <p>Previous audit finding relating to all identified areas of need were not addresses in the care plan. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. The care being provided is individualised and consistent with the needs of residents. Medical and allied health notes are included in the individual file. Activities information is maintained by the activity co-ordinator in the resident file. The initial and on-going assessments include cognitive/mood, sensory/communication, mobility, safety/risk, respiratory/cardiac, continence, activities of daily living, skin/wound care, pain , dietary profile/diabetes management, social/spiritual/cultural and sexuality, activities and interests.</p> <p>Short term care plans are used in conjunction with long term care plans whenever an acute phase of illness or changes to routine give rise to temporary changes in care. Five of the six files (one respite resident) reviewed evidence that the on-going care plans are comprehensive and detailed enough to reflect individualised care, measurable and realistic outcomes. One resident's file evidence updates to interventions and outcomes/goals since her discharge from hospital. The previous audit finding relating to care plans has now been addressed and monitored.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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
<p>Evidence:</p> <p>Six of six care plans reviewed record interventions that are consistent with the resident`s needs and desired goals. One resident file reviewed has the appropriate interventions for challenging behaviour management, risk/safety, medication and cognitive/mood when he presented with aggressive behaviour. Observations on the day of audit indicate residents receiving care that is consistent with their identified needs. The (seven of seven) residents and (three of three) family interviewed report that the service meets their needs/the needs of their relative. The caregivers interviewed report that the care plans are accurate, up to date and do reflect the individual resident`s needs and the interventions to meet these needs effectively. The GP interviewed confirmed that he visits the service almost every day and this was confirmed by the residents interviewed. The GP confirmed that he is informed in a timely manner when there is a change in a residents` health care status.</p> <p>The wound care file evidence that three wounds and seven skin tears are documented on the register. Six of the six wounds (three complex wounds and three skin tears) sampled document assessments that describe the type of wound, size of the wound, type of dressing and frequency of dressing change. Six of six documented wound reviews are done within the stated time frames. Short term care plans are commenced for skin tears and signed and dated when resolved. One complicated lower leg wound has been referred to wound care specialist. The three long term care plans evidence interventions relating to the care of the three more complex wounds. The previous audit evidence relating to wound care assessments has now been monitored and addressed.</p> <p>The ARRC requirements are met.</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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The nurse manager reports that the previous activities co-ordinator has recently resigned. The new activities co-ordinator interviewed has previous experience working in a rest home and has been in the position since January 2014. She works 34 hours per week Monday to Friday and is supported by the nurse manager. Weekend activities are arranged and coordinated by the weekend caregivers.

Information regarding each resident's activity needs, choices and preferences is gathered on admission and regularly reviewed thereafter. Relevant information is shared with members of the multidisciplinary team. Documentation identifies that the activities co-ordinator gains an understanding of a residents' preferred use of time and develops an individual plan that meets their needs, abilities and preference. One on one activity are also provided as required for residents who do not prefer to participate in group activities.

The activities co-ordinator explained how information is sought for each resident, inclusive of choices of activities they enjoy, risk factors with health status, social information, specific health concerns, physical/functional state, interests, hobbies, church affiliations, other relative information and especially their life history. This information forms the basis of developing the resident's activities plan to maintain the resident's strengths and interests. The resident's individual plans (six of six) sighted are reviewed six monthly, signed and dated by the activities co-ordinator and registered nurse.

The activities plans are displayed in each wing, reception area, the lounge and dining room notice boards. Daily activities are arranged seven days a week. Attendance records sighted are maintained. External events as well as internal events are held. The service uses their own van for outings to the Botanical Gardens, afternoon lunches, and morning teas and to exhibitions in the community. The activities plan sighted is meaningful, motivating and maintains special interests of residents. External groups and individual entertainers are welcome and a music session was held on the day of the audit with a regular entertainer who states that he enjoys coming to this facility and to see the residents participating and singing.

Residents (seven of seven) interviewed report that they are satisfied with the variety of planned activities, one reporting that the staff is taking her regularly for a walk.

The ARRC requirements are met.

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: <p>Five of six resident`s care plans reviewed evidence evaluations are recorded at least six monthly by the RN (one respite resident), with input from the care staff and family. The documented evaluations indicate the resident`s progress in meeting goals, there is a multidisciplinary review and the plan is updated to reflect progress towards meeting goals. The long term care plans sighted are individualised and personalised to the resident`s needs. Any changes in the residents` condition are written in the progress notes and discussed at the staff handover at the start of each shift (confirmed at interview with the two senior caregivers).</p> <p>Short term care plans are used to document temporary changes in a residents `condition. The short-term care plan documents the problem, interventions required and outcomes of care. Five of five permanent residents` files reviewed have a short-term care plan signed by an RN .One file evidence a short-term care plan for a chest infection and a date and RN signature when the problem was resolved. Another file evidence a short-term care plan for a UTI with appropriate interventions. The other three files evidence short term care plans for skin tears.</p> <p>The family members (three of three) interviewed report that the nurse manager are available any time if they have a concern or there is a change in the resident`s condition. A record is made by a `relative contacted` stamp in red of any contact with family/whanau.</p> <p>The ARRC requirements are met.</p>

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

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

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

Attainment and Risk: FA

Evidence:

The organisation has policies and procedures in place to reflect safe and timely medicine management. Medications are managed appropriately in line with accepted guidelines.

One senior caregiver administers the medications in the rest home and one senior caregiver administers medications to rest home residents in the serviced apartments. There are documented competencies sighted for the staff designated as responsible for medicine management. The medicine competencies include insulin administration. Training and education is provided.

A senior caregiver was observed administering the lunchtime medications in a safe and appropriate manner. All signing sheets are fully completed on the administration of medicines for the past four weeks. Medicines are stored in locked medicine trolleys and stored in a locked treatment room.

One resident self-administer medicines. His file evidence an assessment was completed by the RN and GP and deemed competent to self-administer. His medication is stored in a locked cupboard in his bathroom and complies with the policy (sighted).

Twelve of twelve medication records reviewed are recorded appropriately and all allergies/sensitivities are recorded in red ink or 'nil known' is documented. Photograph identification is available with all medication records (twelve of twelve). All records reviewed evidence a three monthly medication review done by the GP. Medicines on the medicine chart are individually signed by the GP and individually crossed off, dated and signed where appropriate.

Medico Pak is utilised and all medications are checked on arrival from the pharmacy by the registered nurse.

The controlled drugs are stored in a locked safe in a cupboard in a locked treatment room. The controlled drug record book is available and sighted and evidence weekly checks done in red ink by a RN. Controlled drug elixirs evidence a six monthly physical check. Controlled drugs are delivered by the pharmacists and signed in by the pharmacist and one care staff member. Three of three controlled drug-signing sheets evidence two signatures when administering controlled drugs. The previous audit finding related to control drugs has now been addressed and monitored.

The ARRC requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Beckenham Courts retirement village has a well-run food service that is managed by an experienced cook. The food service is run from a temporary kitchen facility adjacent to the retirement village building. The kitchen includes a cooking area, pantry, storeroom with fridges and freezers. Meals are transported across to the serviced apartments and rest home in Bain mares and served in the two dining rooms. All meals for residents are prepared and cooked on site. The main cook has been in the role for many years and advised that she and other kitchen staff have completed food safety qualifications. The menu is designed by a dietitian and provided by Ryman head office.</p> <p>The food service is notified of dietary requirements via a dietary requirements form, which is completed by the registered nurse and sent through to the kitchen. It includes likes and dislikes, modified diets and preferences. The service provides special equipment eg utensils, lip plates and sipper cups as required. Meals are served directly to residents from the dining rooms. Food temperature recordings are taken each meal for hot dishes prior to serving. Fridge and freezer temperatures are monitored and recorded daily. There are two large fridges, and a large freezer. Food stored in the fridges and freezer is covered and labelled and dated. The kitchen pantry has extra food stores - enough for three days if required in an emergency, including adequate water supply. The service has access to a generator in the event of power failure. A gas BBQ is also available.</p> <p>The registered nurse conducts nutritional assessments on all residents on admission and as needs change. A dietitian is available if required for residents with weight issues. Weights reviewed in six resident plans identified that weights are monitored and are stable. Information is documented in the support plan interventions if there is an identified nutritional issue. Resident weights are monitored monthly or more frequently if required. Seven residents interviewed were complimentary of the food service. Residents and families are surveyed annually with 100% satisfaction noted for meals and food service in the 2013 surveys conducted.</p>

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 1.4.2: 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: The facility displays a current building warrant of fitness, which expires on 1 July 2014.

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

All buildings, plant, and equipment comply with legislation.

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

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

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:

Previous certification audit identified shortfalls around fixtures, fittings and floor and wall surfaces not made of accepted materials for the environment (#1.4.3.4). The areas identified related to the rest home toilets and showers and included (i) a split in the lino at the corner in the Fernwood shower. (ii) A split in the lino at the corner of the flow in the Devon toilet. (iii) A large split in the lino on the kitchen floor. (iv) A large split on the floor of the cleaners' cupboard. (v) The trolley in Southampton has a significant amount of rust. (vi) A split on the floor of the Southampton shower. Advised by the nurse manager that the toilets and showers noted in the previous audit have now been demolished as part of the rebuild and a new cleaner's trolley has been purchased. It is noted that an area of lino split in a bathroom of the rest home has been repaired and silicone sealed, and is cleaned weekly and disinfected with bleach. The service has addressed and monitored this previous finding.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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:

There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service is restraint free and are no residents using enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. The nurse manager (restraint coordinator) and three care givers are familiar with this. Restraint/enabler use is discussed at RAP meetings, and at staff meetings. Restraint review meetings are conducted six monthly. Staff received training around restraint minimisation and safe practice in April 2013. Management of challenging behaviours education was provided in March and September 2013. Restraint questionnaires and competency are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers should this be required.
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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>
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NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

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:

Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly RAP quality meetings, as part of the health and safety/infection control meetings and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager and to organisational management. The registered nurse is the designated infection control nurse and has completed infection control training in October 2013.

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>