Ryman Healthcare Limited - Woodcote

Current Status: 7 April 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 Woodcote is part of a wider village and is situated in Christchurch. The service can provide care for up to 56 residents requiring rest home level care. Occupancy during the audit was 51 residents. The rest home is made up of 49 resident rooms, additionally there are seven serviced apartments certified to provide rest home level care.

Woodcote is managed by an experienced aged care manager (registered nurse) and clinical manager and supported by a stable staff.

All residents and relatives interviewed spoke positively about the care and support provided by staff and management. The service has addressed three of four shortfalls identified at the previous audit around wound documentation, completed induction packages and aspects of medication administration.

Further improvements continue to be required by the service around progress notes.

This audit also identified improvements around complaints documentation and medication documentation.

Audit Summary as at 7 April 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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 7 April 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.		Some standards applicable to this service partially attained and of low risk.

Organisational Management as at 7 April 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.

Continuum of Service Delivery as at 7 April 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.		Some standards applicable to this service partially attained and of low risk.

Safe and Appropriate Environment as at 7 April 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.

Restraint Minimisation and Safe Practice as at 7 April 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.

Infection Prevention and Control as at 7 April 2014

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

HealthCERT Aged Residential Care Audit Report (version 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:	Ryman Healthcare Limited
Certificate name:	Ryman Healthcare Limited - Woodcote

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit		
Premises audited:	Woodcote Retirement Village		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	**Start date:** 7 April 2014	**End date:**	7 April 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:	51

Audit Team

Lead Auditor	XXXXX	**Hours on site**	7	**Hours off site**	4
Other Auditors	XXXXX	**Total hours on site**	7	**Total hours off site**	4
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	1

Sample Totals

Total audit hours on site	14	Total audit hours off site	9	Total audit hours	23

Number of residents interviewed	7	Number of staff interviewed	6	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	43	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 Tuesday, 29 April 2014

Executive Summary of Audit

General Overview
Ryman Woodcote is part of a wider village and is situated in Christchurch. The service can provide care for up to 56 residents requiring rest home level care. Occupancy during the audit was 51 residents. The rest home is made up of 49 resident rooms, additionally there are seven serviced apartments certified to provide rest home level care. There are currently two rest home residents in the serviced apartments. Woodcote is managed by an experienced aged care manager (registered nurse) and clinical manager and supported by a stable staff. All residents and relatives interviewed spoke positively about the care and support provided by staff and management. The service has addressed three of four shortfalls identified at the previous audit around wound documentation, completed induction packages and aspects of medication administration. Further improvements continue to be required by the service around progress notes. This audit also identified improvements around complaints documentation and medication documentation.

Outcome 1.1: Consumer Rights
Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs. An interpreter's policy is in place. The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaints register that is up to date and includes relevant information regarding the complaint. There is an improvement required around complaints documentation.

Outcome 1.2: Organisational Management
The service continues to implement the Ryman quality programme. A quality assistant checklist and Ryman Accreditation Programme (RAP) checklist is forwarded to head office each month to demonstrate implementation of the quality programme. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six-month period. Resident meetings are held on a two monthly basis in each area. Relative meetings are held six monthly. Annual resident and relative surveys are completed. The internal auditing annual schedule is implemented as per schedule. Woodcote has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. The orientation/induction training for caregivers, on completion, is equivalent to foundations level two. There is a specific employees' induction manual. The in-service training programme identifies regular in-services. Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale

Outcome 1.3: Continuum of Service Delivery
Service delivery plans demonstrate service integration. Assessments and support plans identify who is responsible for the actions. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly. Interventions including activities of daily living, management of weight loss and management of challenging behaviours are well documented and implemented. There are improvements

required around progress notes and completing neurological observations following a knock to the head.
There is a comprehensive activities programme at Woodcote. Activities are varied, age appropriate and include inclusion at local community and entertainment events. Referral to other health and disability services is evident in a sample group of resident files.
The medication management system is appropriate. Staff responsible for medication administration are trained and monitored. Medications are reviewed by the residents' general practitioner at least three monthly. Individual resident's medication charts were sighted. There is an improvement required around administering all medications as prescribed and documenting this.
The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission This is reviewed six monthly as part of the care plan review. Relative and resident meetings are held and meals are discussed. All residents interviewed stated that the food was excellent.

Outcome 1.4: Safe and Appropriate Environment

Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness, which expires on 1 June 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2014. Electrical testing occurs two yearly. Hot water is monitored and records show these are maintained within safe limits.
The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Handrails are available around the hallways.
There is an outside area with shade and seating that is observed to be well maintained with paths and handrails.
ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, heel protectors, and lifting aids

Outcome 2: Restraint Minimisation and Safe Practice

The restraint management policies and procedures are comprehensive; include definitions, processes and use of enablers.
The Restraint Minimisation Manual identifies that enablers are voluntary and the least restrictive option. There are no residents requiring restraint and enablers. Training has been provided.

Outcome 3: Infection Prevention and Control

All infections are collected via the 'infection report form', all collected, and discussed at the quality meetings. Following this, the report information is entered onto the computer (Vcare) system and a collated report is generated. Trends and individual outcomes are noted and acted upon by the service. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.
All meetings held include discussion on infection control. Internal audits are completed. Infections are benchmarked across the organisation. There is an improvement required around follow through of meeting minutes

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	13	0	3	0	0	0
Criteria	0	38	0	3	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	34
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	(i)One complaint reviewed in relation to care was documented via emails. A meeting was held with the complainant, but the meeting or outcome was not documented. The complaint register identified that a Quality Improvement Plan (QIP) was established; however, this could not be located. (ii) While staff interviewed felt they were informed about complaints, staff meeting	(i)Ensure complaint outcome and meetings are documented; (ii) ensure meeting minutes identify complaints are discussed with staff and these include actions required.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				minutes did not evidence complaint discussion.		
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Four of six resident files sampled have issues identified that are not followed up in the progress notes. For example, one resident has lost weight but her progress notes have not documented intake for the past three weeks. Another resident was documented to have cyanosed fingers but there is no progress note for a further 48 hours following this.	Ensure that all identified issues are documented and followed through in progress notes.	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	One resident has alanase spray prescribed regularly but this is not signed as given regularly (the clinical manager reports this is a prescribing error but it has not been addressed for three months. This was rectified by the GP	Ensure medications are documented as administered as prescribed.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				during the audit) and three other medication administration signing sheets show that regular blistered medications have not been signed as always administered.		

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: Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Regular contact is maintained with family including if an incident or care/medical issues arise. Access to interpreter services is identified in the community. This includes language support, the DHB, Hearing Association and the Blind Foundation. ARC D11.3 The information pack is available in large print and advised that this can be read to residents. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Interviews with three relatives interviewed all confirmed that they are always informed when their family members health status changes. A sample of incidents forms (15) reviewed identified that all evidenced that family were contacted. Two monthly resident meetings and six monthly relative meetings in each area includes feedback. In the February 2014 relative survey, 83.3% reported communication was good.

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: PA Low
Evidence: The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of complaints, dates and actions taken for resolution. Complaints are documented on VCare. This is also accessible by head office; complaints are given a risk rating. Complaints and verbal complaints reviewed for 2013 (three written, one verbal) and 2014 YTD (three written, one verbal) all were tracked, indicating that they had been actioned according to timeframes and identified resolution. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery. Interviews with three relatives and seven residents confirmed that they were well informed around the complaint process. D13.3h. a complaints procedure is provided to residents within the information pack at entry. There is an improvement required around complaints documentation.

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: PA Low
Evidence: Complaints and verbal complaints reviewed for 2013 (three written, one verbal) and 2014 YTD (three written, one verbal) all were tracked, indicating that they had been actioned according to timeframes and identified resolution. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery. Resident satisfaction survey December 2013 stated 86% were satisfied with the management of complaints. Interviews with three relatives and seven residents confirmed that they were well informed around the complaint process
Finding: (i)One complaint reviewed in relation to care was documented via emails. A meeting was held with the complainant, but the meeting or outcome was not documented. The complaint register identified that a Quality Improvement Plan (QIP) was established; however, this could not be located. (ii) While staff interviewed felt they were informed about complaints, staff meeting minutes did not evidence complaint discussion.
Corrective Action: (i)Ensure complaint outcome and meetings are documented; (ii) ensure meeting minutes identify complaints are discussed with staff and these include actions required.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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 1.2: 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 Woodcote is part of a wider village and is situated in Christchurch. The service can provide care for up to 56 residents requiring rest home level care. Occupancy during the audit was 51 residents. The rest home is made up of 49 resident rooms, additionally there are seven serviced apartments certified to provide rest home level care. There are currently two rest home residents in the serviced apartments. Ryman has robust quality and risk management systems implemented across its facilities that are monitored closely by head office. To monitor organisation performance, the manager reports weekly to head office and RAP committee meetings occur monthly. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality-monitoring programme (RAP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation and there are clear guidelines and templates for reporting. Woodcote objectives in 2014 include (but not limited to); a) working towards excellence in H&S; b) 100% feedback from surveys noting their experience as good or very good; c) RNs become experts in nursing care planning; d) caregivers become proficient in assessing unwell residents; e) having inductions up to date. Reporting on progress to meeting objectives occurs quarterly. The service had in place an experienced and Village Manager registered nurse (RN) who has been in the role for the last 2.5 years. She has attended the yearly Village Manager conference for updates on rollout of specific Ryman objectives and leadership training. She is supported by an experienced clinical manager (RN) whom has been in the role for the last 2.5 years. ARC, D17.3di (rest home), the village manager and clinical manager have maintained at least eight hours annually of professional development activities related to management. Improvement Note: Review currently quality objectives for the year to be measureable (SMART).

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Standard 1.2.3: 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: Woodcote continues to implement a comprehensive quality and risk management system that is directed by head office. The Ryman Accreditation Programme (RAP) includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Woodcote at the onsite monthly RAP staff meetings and weekly management meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with three caregivers and review of meeting minutes demonstrate their involvement in quality and risk activities. The monthly staff meeting (full facility RAP meeting) included discussing progress of 2013 quality goals.

Resident meetings are held on a two monthly basis in each area. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. The relative survey February 2014 identified 100% satisfaction overall and the resident survey December 2013 100% satisfaction overall. A Quality action (QIP) was established and implemented around laundry (75% result).

D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. The RAP programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service's on-going progress around quality improvement. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar (sited). There are adequate clinical policies and procedures to rest home, hospital and dementia level care. The two monthly journal club (attended by the two registered nurses), directed by head office, reviews the latest clinical practice articles.

A quality assistant checklist and RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. a) There is monthly accident/incident reports completed that break down the data collected across the facility. Reports are provided from the manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. Woodcote also provides a six monthly comparative summary report that includes recommendations for residents and staff and training conducted. These are also compared with the previous six month. b) The monthly manager's report includes complaints/concerns/compliments. Quality improvement plans are initiated where required (link 1.1.13.1). c) All infections are documented in a monthly summary report and discussed in the monthly RAP committee meetings and two monthly health and safety/IC meetings. Monthly reports to head office include a monthly summary of infections, statistics, clinical summaries and education. d) Health and safety is addressed through the two monthly health and safety, e) The restraint approval group meets six monthly.
Monthly benchmarking occurs throughout the group, but against themselves.
The service collects data to support the implementation of corrective action plans. Current QIPs in place include: (i) upskilling care staff with assessment of unwell resident; (ii) introduction of symbiotic yoghurt for recurrent UTIs; (iii) resident tripped over vacuum cord.
The internal auditing annual schedule is implemented as per schedule. Meetings are minuted including actions to resolve areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.
Ryman completes spot audits 6 monthly which includes (but not limited to) review of clinical documentation and practise. Last spot audit at Woodcote resulted in QIP that are being actioned and addressed by Woodcote depending on risk.

D19.3 Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed. Risk management, hazard control and emergency policies and procedures are in place. The organisation's benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls and the implementation of the Triple A exercise programme. Sensor mats are in place and manual handling training is provided to staff

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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: The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the Ministry of Health The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. A six monthly comparative analysis is completed of incidents for internal benchmarking. In addition, each facility receives an analysis of the last six monthly periods from which to identify trends and improvements. Minutes of the monthly RAP committee meetings, two monthly health and safety meetings and monthly full facility meetings reflect a discussion of incidents/accidents. Falls rates are compared to indicators from the "Standard on safe indicators in aged care". Monthly analysis of incidents includes comparison with previous month. An Incident Reporting Severity Matrix has been developed by head office and implemented at Woodcote. Incidents are given a risk rating and action required depending on the severity includes instructions for reporting.

Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. A sample of 15 incidents forms reviewed identified that all 15-incident forms were fully completed and included registered nurse assessment.
D19.3b; there is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing

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

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

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

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

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

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

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

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA
Evidence: A register of registered nurse practising certificates is maintained within the facility. The current general practitioners' registration is printed from the professional body's website. Allied health practitioners are asked to provide evidence of registration as appropriate (for example, physiotherapist and podiatrist) and a copy is retained by the facility. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed. All had completed reference checks, orientation and up to date appraisals. Woodcote has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. It is tailored specifically to each position such as (but not limited to) caregiver, senior caregiver, registered nurse, Health & Safety representative, clinical manager and maintenance. The orientation/induction training for caregivers, on completion, is equivalent to foundations level two. There is a specific employees' induction manual. The previous finding around completion of inductions have been completed. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent. The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme to achieve ACE core, ACE advanced and/or ACE dementia, as appropriate, if not achieved prior to employment. The 2013 in-service training programme well exceeded eight hours annually. The training programme is also supported by staff comprehension surveys at least two annually. Registered nurses are supported to maintain their professional competency and there is also a foreign-trained nurse development programme. Staff training records are maintained. The journal club for qualified nurses meets two monthly. As part of the training sessions, research articles are reviewed and specific questions are assigned, relating to each article, for discussion. The journal club has completed training (YTD) around pressure areas and palliative care. Yearly formal performance review specific to RNs for reflective practice and setting goals including up skilling or other training or qualification goals.

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

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)
A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

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 1.2.8: 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 staffing levels and skills mix policy that documents rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents and rosters are in place. Staff reported that staffing levels were adequate and they were well supported by management. Across the facility, there is a Village Manager (RN) and a clinical manager/Deputy Manager (RN). There is a RN on duty seven days a week. Interviews with three caregivers (AM and PM shift), confirmed that staffing numbers were good across all shifts. Interviews with seven residents and three relatives confirmed staffing was satisfactory.

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; D16.5ci; 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: PA Low

Evidence:

The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission. The nursing care assessments and long-term care plans are completed within three weeks and align with the service delivery policy.
The nursing care assessment and service delivery policy and nursing care assessment and planning interventions policy describe the responsibility around documentation.
Wound care folders evidenced in all areas and assessments are signed by a registered nurse. Activity assessments and activities care plans have been completed by the activity therapists.
There is a continuum of service delivery policy that includes guidelines for a) nursing care assessment, b) planning care interventions, c) service delivery/interventions, and d) evaluation and care plan review. Timeframes are identified for assessment, initial care plan, long-term care plan and evaluations. Staff were familiar with the timeframes and files reviewed were kept up to date.

D16.2, 3, 4; An assessment and initial care plan is completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months in five of six resident files. One resident is on short-term respite care.
D16.5e; Medical assessments were documented in all five long-term files within 48 hours of admission. Three monthly medical reviews were documented in five of six files by general practitioner. One resident is on short-term respite care. It was noted in five of six resident files reviewed identified that the GP has assessed the resident as stable and is to be seen three monthly. More frequent medical assessment/ review noted occurring in residents with acute conditions.
Assessment tools completed on admission include a) pressure area risk assessment, b) skin integrity, c) continence, d) mobility, e) falls risk, f) cultural assessment and nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

Staff could describe a verbal handover each duty that maintains a continuity of service delivery. There is a duty handover supplement document which is completed for

each shift that lists staff allocations, notes any residents requiring any special observations or needs and also advises of who is on call and who is the designated fire warden for that shift. There is one house GP involved with the service and he visits at least weekly. Progress notes are maintained. Progress notes are written at least weekly and document the time they are written. This is an improvement since the previous audit. The file for the respite resident and the file for the resident from the serviced apartments show all issues are followed through in the progress notes. The other four files have issues identified that are not followed up in the progress notes. For example, one resident has lost significant weight but her progress notes have not documented intake for the past three weeks. This resident was documented to have cyanosed fingers but there is no progress note for a further 48 hours following this. This previously identified shortfall continues to require improvement.

The GP interviewed stated that the service is excellent. He reported good communication and believes the care provided is of the highest standard.

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

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

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: PA Low
Evidence: Staff could describe a verbal handover each duty that maintains a continuity of service delivery. There is a duty handover supplement document which is completed for each shift that lists staff allocations, notes any residents requiring any special observations or needs and also advises of who is on call and who is the designated fire warden for that shift. There is one house GP involved with the service and he visits at least weekly. Progress notes are maintained. Progress notes are written at least weekly and document the time they are written. This is an improvement since the previous audit. The file for the respite resident and the file for the resident from the serviced apartments show all issues are followed through in the progress notes.
Finding: Four of six resident files sampled have issues identified that are not followed up in the progress notes. For example, one resident has lost weight but her progress notes have not documented intake for the past three weeks. Another resident was documented to have cyanosed fingers but there is no progress note for a further 48 hours following this.
Corrective Action: Ensure that all identified issues are documented and followed through in progress notes.
Timeframe (days): 90 *(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: Six resident files were reviewed (including one from serviced apartments). The seven residents interviewed reported their needs were being appropriately met. The care plan includes; cognitive/mood, sensory/communication,

mobility, safety/risk, respiratory/cardiac, continence, medication, ADLs, skin, wound and pressure care, pain, dietary/diabetes management, and social, spiritual, cultural and sexuality. Care plans were current and family were invited to attend review meetings (correspondence noted in files reviewed). Interview with the clinical manager verified involvement of families in the care planning process.
Two incident forms were sampled for a resident with a fall resulting to a knock to the head. Neurological observations were completed. This is a previously identified shortfall that has been addressed. The recording of Neurological Observations by senior caregivers had been identified in December 2013 as a learning opportunity following a review of incident report forms. A Quality Improvement Plan was raised on 10 Jan 2014, education was held for caregivers on 29 Jan 2014, which was attended by 16 caregivers, and those who did not attend completed an Assessment Skills Checklist. Neurological observations completed (29 Mar 2014) following this training evidence correct recordings and documentation.

The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives. There were short term care plans in five of the six files reviewed. The other resident has not had any short term needs.
Four files showed a link between short term care planning and wound management plans (the other two residents have not had wounds).
D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.
Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.
Specialist continence advice is available as needed and this could be described.
Continence management in-services and wound management in-service have been provided.
Wound assessment and wound management plans/skin tear plans are in place for five wounds. There is one current pressure area. There is a wound and skin tear register. Evaluations, wound assessments and pain level are carried out at each dressing change. Wound mapping charts and photographs are evident as required. All wound charts document the type of wound and the frequency with they should be evaluated and all have been reviewed within stated timeframes. These are improvements since the previous audit. The clinical manager interviewed also has access to external to wound specialist as required.

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: There are two activity coordinators (who cover the rest home and the serviced apartments). The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility. The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences', Next of kin input into care and an activities care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community. This is a well-designed and comprehensive programme that meets the needs of all consumers. The programme is evaluated and can be individually tailored according to resident's needs. Residents are able to participate in community activities as well as activities in the service itself. There are monthly bowls competitions with other facilities. Activities include (but not limited to): outings, triple A exercise, programme, music, crafts, shopping, happy hour, reading, and quizzes. The triple A (Active, Ageless, Awareness) exercise programme was designed by the Ryman group and includes chair exercises for less active residents and more active exercise programme for mobile residents and serviced apartments. There are different levels of the programme depending on the mobility level of the residents. Resident meetings are held bi-monthly and feedback to activities is also provided at the meeting. All seven residents and three family interviewed discussed enjoyment in the programme and the diversity offered to all residents. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed.

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

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

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

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

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

Attainment and Risk: FA
Evidence: The evaluation and care plan review policy require that care plans are reviewed six monthly. The Vcare evaluation template describes progress against every goal and need identified in the care plan (sighted). Short term care plans are well utilised. Any changes to the long term care plan are dated and signed. Five care plans reviewed (one resident is on respite care) included handwritten updates to the plan as needs have changed. Short term care plans were cited for wounds, weight loss, UTIs and poor appetite. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. ARC: D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: PA Low
Evidence: The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the clinical manager and a senior caregiver. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication administration was observed at lunchtime and practice observed was good including all residents being observed to take their medication. This is an improvement since the previous audit. Medications and associated documentation is kept on the medication trolleys in the nurse's office. Senior caregivers deemed competent are responsible for administering medication. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. Controlled drugs are stored in a locked cabinet inside the locked nurse's office. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly. Medication fridges are monitored weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. This was cited in the respite file reviewed. Resident photos and allergies are on all the drug charts. All senior caregivers administering medication complete a medication package. An annual medication administration competency is completed of each staff member. Medication training and competencies last occurred in 2013. There is a self-medicating resident's policy in place. A self-medication assessment checklist is available and has been completed and reviewed six monthly for the two residents who self-administer (one resident fully self-administers and one who self-administer inhalers and eye drops). Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. Two residents have alternative remedies and these are both prescribed by the doctor. This is an improvement since the previous audit. One resident has a spray prescribed regularly but this is not given regularly (the clinical manager reports this is a prescribing error but it has not been addressed for three months. It was deleted from the chart by the GP during the audit) and three other medication administration signing sheets show that regular blistered medications have not been always administered. This is an area requiring improvement. D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Low
Evidence: The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the clinical manager and a senior caregiver. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication administration was observed at lunchtime and practice observed was good including all residents being observed to take their medication. This is an improvement since the previous audit. Medications and associated documentation is kept on the medication trolleys in the nurse's office.
Finding: One resident has a spray prescribed regularly but this is not signed as given regularly (the clinical manager reports this is a prescribing error but it has not been addressed for three months. This was rectified by the GP during the audit) and three other medication administration signing sheets show that regular blistered medications have not been signed as always administered.
Corrective Action: Ensure medications are documented as administered as prescribed.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: All kitchen staff have completed Food Safety Certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller and a pantry. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a three monthly rolling menu. All meals are cooked in the main kitchen and served from the kitchen directly to the residents in the dining room. Meals are delivered to serviced apartments in insulated containers. There are also snacks available over 24 hours for residents. Diets are modified as required. There are currently a number of diabetic residents and one vegetarian being catered for as well as high calorie meals. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. Food safety in-service is completed by ECOLAB. There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets. Residents with special dietary needs have a nutritional profile completed on admission. This is reviewed six monthly as part of the care plan review. Changes to resident's dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the kitchen notice board, which can be viewed only by kitchen staff.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.2: 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: Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness, which expires on 1 June 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2014. Electrical testing occurs two yearly. Hot water is monitored and records show these are maintained within safe limits. The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. Hand rails are available around the hall ways. There is an outside area with shade and seating that is observed to be well maintained with paths and handrails. ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, heel protectors, and lifting aids.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

Attainment and Risk: FA
Evidence:

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

Criterion 1.4.2.6 (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):	*(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: The restraint management policies and procedures are comprehensive; include definitions, processes and use of enablers. The Restraint Minimisation Manual identifies that enablers are voluntary and the least restrictive option. There are no enablers or restraints utilised at Woodcote. Challenging behaviour and restraint training has been provided to staff.

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

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

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

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: All infections are collected via the ' infection report form' and all collected and discussed at the RAP meetings. Following this, the report information is entered onto the VCare system and a collated report of generated. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers. The IC Officer then reports infection stats to the bimonthly H&S/IC meetings and a six monthly comparative summary is completed and forwarded to head office. All meetings held include discussion on infection control. Internal audits are completed. Infections are benchmarked across the organisation.

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

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

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

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

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA
Evidence:

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