

Ryman Healthcare Limited - Ngaio Marsh Retirement Village

Current Status: 16 June 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 Ngaio Marsh is part of a wider village and is situated in Christchurch. The service provides hospital and rest home level of care. Occupancy during the audit was 48 hospital level, 49 rest home level and 11 residents receiving rest home level care in the serviced apartments.

Ngaio Marsh is managed by an experienced manager (registered nurse) and clinical manager. Both managers have been employed since last audit and come to the service with management experience and are supported by an assistant manager (enrolled nurse) and a stable team of staff. All residents and relatives interviewed spoke positively about the care and support provided by staff and management.

The previous shortfalls around the documentation of outcomes of written evaluations in the care plan and weight management has been addressed. This audit identifies an improvement is required around the documentation of interventions to reflect the resident's current needs.

Audit Summary as at 16 June 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

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

Consumer Rights as at 16 June 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 16 June 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 16 June 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 medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 16 June 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 16 June 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 16 June 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 4.2)

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 - Ngaio Marsh Retirement Village
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Ngaio Marsh Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 June 2014 End date: 17 June 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:	118

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXXXXX	Total hours on site	12	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	12	Total audit hours	36
Number of residents interviewed	9	Number of staff interviewed	15	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	8	Total number of managers (headcount)	4
Number of medication records reviewed	16	Total number of staff (headcount)	118	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXXXX, 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 July 2014

Executive Summary of Audit

General Overview

Ryman Ngaio Marsh is part of a wider village and is situated in Christchurch. The service provides hospital and rest home level of care. Occupancy during the audit was 48 hospital level, 49 rest home level and 11 residents receiving rest home level care in the serviced apartments. Ngaio Marsh is managed by an experienced manager (registered nurse) and clinical manager. Both managers have been employed since last audit and come to the service with management experience and are supported by an assistant manager (enrolled nurse) and a stable team of staff. All residents and relatives interviewed spoke positively about the care and support provided by staff and management.

The previous shortfalls around the documentation of outcomes of written evaluations in the care plan and weight management has been addressed. This audit identifies an improvement is required around the documentation of interventions to reflect the resident's current needs.

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.

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.

Ngaio Marsh 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

The registered nurses are responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status. The previous shortfall around the documentation of outcomes of written evaluations in the care plan and weight management is addressed. This audit identifies an improvement around the documentation of interventions to reflect the resident's current needs.

Resident files are integrated and include notes by the GP and allied health professionals. The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the resident group. Spiritual and cultural preferences and needs are being met.

Education and medicines competencies are completed by all staff responsible for administration of medicines. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, allergies and special instructions for administration.

Food services and all meals are provided on site and transported to the hospital and serviced apartments in hot boxes. Resident's individual food preferences and dislikes are not known by staff serving the meals. There is dietitian review of the menu. All staff are trained in food safety and hygiene.

Outcome 1.4: Safe and Appropriate Environment

The building has a current warrant of fitness. A reactive and preventative planned maintenance schedule is in place. Clinical equipment is calibrated and checked annually. Electrical testing occurs annually.

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 currently three residents requiring restraint and no residents using an enabler. 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.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	0	1	0	0
Criteria	0	41	0	0	1	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	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)There are no documented pressure area interventions for one rest home resident in the serviced apartment assessed with a high risk of pressure areas (corrected on day of audit). (ii) There is a short term care plan in place for one hospital resident however does not reflect the resident's current dietary requirements and outcome of the dietitian visit; (iii) There are no documented management strategies in place for one hospital resident with altered behaviours. (iv) There is no short term care plan for a rest home resident in a serviced apartment with changes to health status and monitoring	Ensure interventions are documented in the care plans to reflect the residents current needs.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				requirements as instructed by GP (corrected on day of audit). (v) Two residents (one hospital and one rest home) with an enabler in use do not have enabler risks identified in the care plan.		

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 six relatives (one rest home and five hospital) interviewed all confirmed that they are always informed when their family members health status changes.

Two monthly resident meetings and six monthly relative meetings in each area includes feedback.

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 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 2014 year to date (YTD) (two written, seven 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 six relatives (five hospital and one rest home) and nine residents (seven rest home and two hospital) 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.

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): *(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:

Ngaio Marsh is part of a wider village and is situated in Christchurch. The service provides hospital and rest home level of care for up to 134 residents (including rest home care in 20 certified serviced apartments). Occupancy during the audit was 48 hospital level residents, 49 rest home level residents and 11 residents receiving rest home level care 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.

Ngaio Marsh objectives in 2014 include (but not limited to); a) reducing incidence of falls and wounds b) stabilizing the team and reduce staff turnover; c) manage refurbishment with as little disruption as possible, and d) manage hazards.

The service had in place a Village Manager, registered nurse (RN) who has been in the role for the 3 months, who has management experience. She is supported by an experienced clinical manager whom has been in the role for eight months.

D17.3di: the village manager and clinical manager have attended at least eight hours of professional development activities related to management and are scheduled to attend manager's conference at the end of June 2014.

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:

Ngaio Marsh continues to implement a comprehensive quality and risk management system that is directed by head office. The RAP includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Ngaio Marsh 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 2013/2014 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. In the February 2014 rest home/hospital resident/relative survey resulted in 90% rating the experience at Ngaio Marsh as very good. In the serviced apartments satisfaction survey (December 2013) the overall satisfaction result was 88%.

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 enrolled

and 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. Ngaio Marsh 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 weekly manager's report includes complaints. Quality improvement plans are initiated where required. 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: the resident/relative survey improvements including food service, missing items of clothing and associated naming of clothing, and improvement of staff communication.

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 six monthly which includes (but not limited to) review of clinical documentation and practise.

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 Ngaio Marsh. 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 18 incident forms reviewed identified that all 18 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 all health professionals is maintained on site and this includes registered nurses, enrolled nurses, general practitioners, physiotherapist, pharmacist and podiatrist.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed. All had completed reference checks, orientation and up to date appraisals.

Ngaio Marsh 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 and 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 2013/2014 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 new graduate/ 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. 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), a clinical manager, Deputy Manager (RN) and a serviced apartment's coordinator, enrolled nurse (EN). There is a RN on duty seven days a week.

Interviews with five caregivers who work AM and PM shifts (two hospital, two rest home and one serviced apartment care giver), confirmed that staffing numbers were good across all shifts. Interviews with nine residents (two hospital, seven rest home) and six relatives (five hospital, one rest home) 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: FA

Evidence:

The service provides hospital and rest home level of care including rest home care in 11 serviced apartments. The registered nurses (RN) 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. Enrolled nurse/serviced apartment co-ordinator develops care plans and undertakes assessments along with an RN.

The nursing care assessment and service delivery policy and nursing care assessment and planning interventions policy describes the responsibility around documentation. Activity assessments and activities plans have been completed by the activity officers.

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 are familiar with the timeframes and files reviewed were overall kept up to date.

D16.2, 3, 4; An initial assessment is completed within 24 hours, initial care plan within 48 hours and long term care plan within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. Eight resident files were reviewed (four rest home, four hospital). Six of seven long term residents had the

initial admission assessments and plans and the long term care plan completed by the registered nurses/enrolled nurse within the required timeframe. One hospital resident is respite care and another hospital resident has not been at the service long enough.

D16.5e; Medical assessments are documented in all seven long term files within 48 hours of admission. The respite care file had current GP information letter. Three monthly medical reviews are documented in five of seven files by general practitioner. Two residents (one rest home and one hospital) are not due for a three monthly medical review. More frequent medical assessment/ review is noted occurring in residents with acute conditions and those requiring palliative care. The service has three GPs from a local medical contracted to provide medical services. Each GP visits one a week and sees each other's patients of concern. Locum cover is provided for GP leave. The GP (interviewed) states the RN can contact the for telephone advice or request visits by phoning then directly at the practice, emails, faxes and on their cell phone. The GP is available on call and 24 hours for palliative care patients. The GPs meet with families for all new admissions and at the three monthly multidisciplinary reviews (MDR).

The staff interviewed (five caregivers - two rest home, two hospital, one serviced apartment) could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Duty Handover sheets note any residents requiring any special observations or needs. Progress notes are maintained at least daily for rest home and each shift for hospital residents or more frequently as required. Eight files (four rest home and four hospital) reviewed evidence this is occurring.

The service employs a physiotherapist for 12 hours per week who conducts an initial resident mobility assessment on admission. The RN refers any resident mobility/falls concerns to the physiotherapist (physio). There is evidence of physio follow-up and an exercise plan in the resident file of a frequent faller. Two physio assistants are employed to support the physio and ensure physio instructions; exercises, walks etc. are carried out. The physiotherapist is involved in the MDR as relevant. Safe manual handling education for staff was last provided March 2014.

There is a close liaison between the service and needs assessors, mental health services for the older person, palliative care services and the geriatrician as required. The podiatrist visits six weekly.

Four rest home level resident files are viewed as follows; 1) resident in serviced apartment with weight loss 2) resident with frequent falls 3) resident with challenging behaviours and enabler 4) resident on controlled drug pain management and weight loss.

Four hospital level resident files are viewed as follows; 1) respite care resident 2) resident with grade 2 pressure areas 3) resident with complex medical conditions. 4) Resident with memory loss and challenging behaviour

Tracer methodology hospital resident.

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

Tracer methodology rest home resident:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The outcomes of six monthly written evaluations in six of eight long term resident files are transferred to the long term care plan. One hospital resident is respite care and another hospital resident has not been at the service six months. The previous finding at certification audit has been addressed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Eight resident files were reviewed (four rest home, four hospital). Residents interviewed (seven rest home, two hospital) report their needs are being appropriately met. Relatives interviewed (one rest home, five hospital) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required.

Assessment tools completed on admission include a) waterlow pressure area risk assessment, b) three day continence diary, c) physio mobility assessment, d) coombes falls risk, e) nutritional assessment as applicable, f) pain assessment, g) wound assessment, h) behaviour assessment, and j) restraint/enabler assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and treatment plan and evaluations are in place for four skin tears and three wounds (leg, face and heel) in the rest home unit. There are seven skin tears in the hospital unit, one lesion and one hammer toes. There are three pressure areas in the hospital unit (grade 2 pressure area, grade 1 pressure area sacrum and a healing pressure area of heel. All wounds have completed wound assessments, treatment and evaluation plans. Dressing changes are completed as directed. All skin tears have a completed short term care plan. Two non-healing skin tear treatments have been transferred onto a full wound assessment plan. GPs are notified of all wounds and non-healing skin tears. There are pre-printed faxes for use (sighted). Wound care and advice is available from the site Wound Champion and the Ryman Wound Champion. Wound nurse specialist advice is readily available as required. There is an improvement required around the documentation of pressure area interventions.

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 by the clinical manager and two RN's interviewed. Continence management education was provided in March 2014 (26 staff).

Calibrated weighing scales are used to weigh residents monthly. Weight loss short term care plans are in use as evidenced which include drink supplements, food and fluid monitoring, frequency of weighing, GP/Dietitian notification. The resident dietary requirements is reviewed and a copy sent to the kitchen. A dietician is available as required and notified for any weight loss of 2kg or more per month. Food and fluid monitoring charts are evidenced in use. There is an improvement required around the review of weight loss short term care to ensure the resident's current dietary requirements are current. The previous finding at certification audit around weight management has been addressed.

Behaviour assessments and behaviour nursing care plans are completed for residents with challenging behaviours. A Behaviour chart is evidenced in use for a hospital resident exhibiting altered behaviours. The behavioural incidents have been reported in the progress notes. A referral to psychiatry services has been actioned with a visit for one hospital resident with altered behaviours. There is an improvement required around documented interventions for altered behaviour.

Short term care plans are available for use to document interventions for short term needs/changes to health. Relatives interviewed state they are kept informed of any changes to the resident's health. There is an improvement required around the documentation of risks associated with enabler use for one hospital resident and changes to health status for one hospital resident.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: PA Moderate

Evidence:

Wound assessment and treatment plan and evaluations are in place for four skin tears and three wounds (leg, face and heel) in the rest home unit. There are seven skin tears in the hospital unit, one lesion and one hammer toes. There are three pressure areas in the hospital unit (grade 2 pressure area buttocks, grade 1 pressure area sacrum and a healing pressure area of heel. All wounds have completed wound assessments, treatment and evaluation plans. Dressing changes are completed as directed. All skin tears have a completed short term care plan. Two non-healing skin tear treatments have been transferred onto a full wound assessment plan. GPs are notified of all wounds and non-healing skin tears. There are pre-printed faxes for use (sighted). Wound care and advice is available from the site Wound Champion and the Ryman Wound Champion. Wound nurse specialist advice is readily available as required.

Calibrated weighing scales are used to weigh residents monthly. Weight loss short term care plans are in use as evidenced which include drink supplements, food and fluid monitoring, frequency of weighing, GP/Dietitian notification. The resident dietary requirements is reviewed and a copy sent to the kitchen. A dietician is available as required and notified for any weight loss of 2kg or more per month. Food and fluid monitoring charts are evidenced in use. There is an improvement required around the review of weight loss short term care to ensure the resident's current dietary requirements are current.

Behaviour assessments and behaviour nursing care plans are completed for residents with challenging behaviours. A behaviour chart is evidenced in use for a hospital resident exhibiting altered behaviours. The behavioural incidents have been reported in the progress notes. A referral to psychiatry services has been actioned with a visit for one hospital resident with altered behaviours.

Short term care plans are available for use to document interventions for short term needs/changes to health. Relatives interviewed state they are kept informed of any changes to the resident's health.

Assessment tools completed on admission include a) waterlow pressure area risk assessment, b) three day continence diary, c) physio mobility assessment d) coombes falls risk e) nutritional assessment as applicable f) pain assessment g) wound assessment h) behaviour assessment and j) restraint/enabler assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

Finding:

(i) There are no documented pressure area interventions for one rest home resident in the serviced apartment assessed with a high risk of pressure areas (corrected on day of audit). (ii) There is a short term care plan in place for one hospital resident however does not reflect the resident's current dietary requirements and outcome of the dietitian visit; (iii) There are no documented management strategies in place for one hospital resident with altered behaviours. (iv) There is no short term care plan for a rest home resident in a serviced apartment with changes to health status and monitoring requirements as instructed by GP (corrected on day of audit). (v) Two residents (one hospital and one rest home) with an enabler in use do not have enabler risks identified in the care plan.

Corrective Action:

Ensure interventions are documented in the care plans to reflect the residents current needs.

Timeframe (days): 90 (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 three activity officers that provide separate activity programmes for the rest home, hospital and serviced apartments. Activities are provided from Monday to Friday in the rest home and serviced apartments and seven days a week for the hospital residents. A company diversional therapist oversees the activity programmes. The activity officers attend Ryman workshops and on-site in-services. All hold a current first aid certificate.

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 displayed on notice boards around the facility. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme that was designed by the Ryman group and includes exercises for less active residents and a more active exercise programme for mobile residents and serviced apartments. Other activities in the units are delivered to meet the cognitive, physical, intellectual and emotional needs of the consumer group. The community centre is used for larger functions and all residents are invited to attend. Entertainers and community members visit the service. Community links are maintained with RSA, Cashmere club Salvation army, school children and churches. A special needs group of children visit the service weekly and have built a special rapport with the residents. Presbyterian and Anglican Church services are held weekly and Catholic communion weekly.

There are weekly outings for all the units. The service has two vans and hire wheelchair taxis for hospital residents in wheelchairs. Weekly contact is made with residents who choose not to participate in the group programme and one on one time such as discussion and reminiscing is spent with them.

The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences'. The activity plan (spice of Life) is reviewed six monthly by the activity co-ordinator with the resident/family and RN.

The activity plan includes headings for comfort and wellbeing, outings, interests and family and community. A resident attendance list is maintained for activities, entertainment and outings.

Resident meetings are held and feedback to activities is provided at the meeting. Relative meetings are held two monthly. Resident and relative surveys provide feedback on the activity programme.

All residents (seven rest home and two hospital) interviewed discussed enjoyment in the programme and the diversity offered to all residents.

D16.5d The review of the activity plan is at the same time as the care plan.

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 written evaluation template describes progress against every goal and need identified in the care plan. Six of eight resident files sampled (four rest home, two hospital) contained written evaluations completed six monthly. One hospital resident is on respite care and one hospital resident has not been at the service six months. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems.

D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service uses individualised medication blister packs for regular and prn medications. Medication reconciliation is completed on admission and the blister packs are signed by the RN checking the medications. Any discrepancies are fed back to the pharmacy. The medication trolleys are kept in locked treatment rooms in the rest home and hospital units and serviced apartments. RN's, enrolled nurses and senior caregivers are competency assessed annually (January 2014) and responsible for administering medication. Medication education was completed 23 May 2014 and Pain and symptom management 27 May 2014. RN's complete syringe driver training and annual refreshers at the hospice. Controlled drugs are stored in a locked cabinet in the hospital and rest home medication rooms. Controlled drugs for the serviced apartments are kept in the rest home drug safe. There are weekly controlled drug checks and the clinical manager and RN complete six monthly audits of controlled drugs. Standing orders in use are current. There is one resident self-medicating eye drops. The resident has a self-medicating assessment which is reviewed three monthly by the GP and RN. Self-medication is monitored by the RN on duty. Administration signing sheets reviewed are correct and complete. Two medication competent persons sign for the administration of controlled drugs. PRN medications administered have a date and time of administration recorded. Expiry dates are checked monthly. Eye drops are dated on opening. Medication fridge temperatures are monitored weekly. Emergency oxygen, oxygen concentrators and suction is checked weekly. Medication audit was completed March 2014-98% compliance.

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. The medication folder contains individual resident special instructions, blood sugar level monitoring, diabetic management and antibiotic use. All 16 medication charts reviewed charts have photo identification and an allergy status documented on the medication chart.

D16.5.e.i.2; Sixteen medication charts reviewed (eight rest home and eight hospital) identified that the GP had seen the resident 3 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: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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:

There is a qualified head chef Sunday to Thursday and a qualified cook Friday and Saturday. The chef/cook is supported by an assistant cook and two kitchen hands on the morning shift. The four weekly seasonal menu is designed and reviewed by a Registered Dietitian (March 2014) at an organisational level. All meals and morning teas are cooked on site. The hot meal is at midday with a lighter tea. Caregivers serve the prepared lighter tea. The cook receives a resident dietary needs form for each resident on admission and is notified of any changes to dietary requirements such as soft, pureed or modified diets or any resident with weight loss. Likes, dislikes and special diets are known in all the resident units where meals are served. Alternative meals are offered for those residents with dislikes or religious preferences. Menus are displayed in the dining rooms. Meals are delivered in hot boxes to the hospital and serviced apartments. Meals in rooms are delivered by trolley with meals plated and kept hot with heat lids. Lip plates and special utensils are available for residents to promote independence with meals.

The service has a large workable kitchen with a separate area for dishwashing, food preparation and cooking. There is a large walk-in chiller, fridges and freezers and a dry goods storage area. All dry goods are in sealed containers, labelled and off the floor. Stock is rotated when goods are delivered.

The chiller and freezer temperatures are recorded daily. Hot food monitoring has been completed three monthly however daily monitoring is implemented on the day of audit to reflect current best practice in food safety. Staff are observed wearing correct personal protective clothing. Chemicals are stored safely when the kitchen is unattended. Cleaning schedules are maintained.

Nine residents interviewed (seven rest home and two hospital) are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings, food comments books in the dining rooms and resident surveys. 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.

D19.2 Food services staff have completed NZQA Module 1 in food safety (includes workbook) and chemical safety.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.2: 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 August 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 outside seating areas with shading and an internal atrium area with seating that is observed to be well maintained with walkways.

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 three residents using restraint and no enablers utilised at Ngaio Marsh. At time of audit Challenging behaviour and restraint minimisation 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.)*