Malvina Major Retirement Village Limited

Current Status: 3 July 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

Malvina Major provides care across two levels. The ground floor has 60 rest home beds, of which 20 have been assessed as suitable for either rest home and/or hospital level (i.e. dual service). Level one has 60 hospital level beds, in addition 20 of the serviced apartments have been certified suitable for rest home level residents. On the day of audit there was a total of 49 rest home residents and 70 hospital level residents.

The levels are the same layout with the upper level being accessible by lift or stairs. At the time of audit there are two rooms in both the hospital and rest home that are being refurbished, and one vacant room (rest home).

The village manager at Malvina Major has been in post since September 2013 and comes from a hospitality background. The village manager has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. He is supported by an assistant manager who carries out administrative functions (in post since September 2013) and a clinical services manager (RN) who oversees clinical care at the care centre. The clinical services manager has worked in a range of health care settings including aged care and district health boards. She has been in post since October 2013. The management team is supported by the Ryman management team including the regional manager.

All residents and relatives interviewed spoke positively about the care, support and communication provided at Malvina Major. The service has made considerable improvements around systems and processes since the previous audit and has addressed 12 of the 14 previous shortfalls identified at their last certification audit. Improvements continue to be required around data collection and care plan interventions.

This audit identified further improvements required around evaluation of corrective action plans and medication management.

Audit Summary as at 3 July 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

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

Consumer Rights as at 3 July 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.

Organisational Management as at 3 July 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.		Some standards applicable to this service partially attained and of low risk.

Continuum of Service Delivery as at 3 July 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.

Safe and Appropriate Environment as at 3 July 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 3 July 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 3 July 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 4.2

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:	Malvina Major Retirement Village Limited
Certificate name:	Malvina Major Retirement Village Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit			
Premises audited:	Malvina Major 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:**	3 July 2014	**End date:**	4 July 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:	119

Audit Team

Lead Auditor	XXXXXXX	**Hours on site**	15	**Hours off site**	6
Other Auditors	XXXXXXX	**Total hours on site**	15	**Total hours off site**	5
Technical Experts	XXXXXXX	**Total hours on site**	15	**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXXX			**Hours**	1

Sample Totals

Total audit hours on site	45	Total audit hours off site	12	Total audit hours	57

Number of residents interviewed	13	Number of staff interviewed	25	Number of managers interviewed	3
Number of residents' records reviewed	9	Number of staff records reviewed	10	Total number of managers (headcount)	3
Number of medication records reviewed	22	Total number of staff (headcount)	200	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	2

Declaration

I, XXXXXXX, 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 Wednesday, 13 August 2014

Executive Summary of Audit

General Overview

Malvina Major provides care across two levels. The ground floor has 60 rest home beds, of which 20 have been assessed as suitable for dual purpose – i.e. rest home and/or hospital level. Level one has 60 hospital level beds, in addition 20 of the serviced apartments have been certified suitable for rest home level residents. On the day of audit there are 45 rest home and 12 hospital level residents (of 60) on the ground floor, 58 (of 60) hospital residents, and four rest home residents in the serviced apartments. This gives a total of 49 rest home residents (including one respite) and 70 hospital level residents.

The levels are the same layout with the upper level being accessible by lift or stairs. At the time of audit there are two rooms in both the hospital and rest home that are being refurbished, and one vacant room (rest home).

The village manager at Malvina Major has been in post since September 2013 and comes from a hospitality background. The village manager has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. He is supported by an assistant manager who carries out administrative functions (in post since September 2013) and a clinical services manager (RN) who oversees clinical care at the care centre. The clinical services manager has worked in a range of health care settings including aged care and district health boards. She has been in post since October 2013. The management team is supported by the Ryman management team including regional manager.

All residents and relatives interviewed spoke positively about the care, support and communication provided at Malvina Major. The service has made considerable improvements around systems and processes since previous audit and have addressed 12 of the 14 previous shortfalls identified at their last certification audit. Improvements continue to be required around data collection and care plan interventions.

This audit identified further improvements required around evaluation of corrective action plans and medication management.

Outcome 1.1: Consumer Rights

There is an open disclosure policy. Interviews with residents and relatives confirm family are kept informed of their family member's current health status including any adverse events. A complaints process is being implemented. The finding from the certification audit relating to file security and care planning is now met.

Outcome 1.2: Organisational Management

Malvina Major is implementing the Ryman Accreditation Programme (RAP) that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Malvina Major provides clinical indicator data for the two services being provided (hospital and rest home). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is

an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. The findings from the certification audit relating to the quality programme, developing corrective action plans, notification to relevant authorities, staff appraisals, training and mentoring are now met. There are two improvements required around data collection and evaluation of corrective action plans.

Outcome 1.3: Continuum of Service Delivery

The registered nurses are responsible for undertaking the assessments on admission. Communication with family is recorded. The long term care plan includes nursing diagnosis, objectives of nursing care, setting goals, and details of implementation. Short term care plans are utilised for changes in health status, such as wound care, weight loss and infections and this is an improvement on previous audit. There continues to be improvements required around aspects of care planning documentation.

Activities programmes are planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. 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.

The medication management system includes a policy that follows recognised standards and guidelines for safe medicine practice. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents' general practitioner at least three monthly. There is an imrpovement required arounbd medication management.

The service has a large workable kitchen with a menu is designed and reviewed by a registered Dietitian, staff at the facility have completed food safety training. Two monthly resident meetings are held and meals are discussed. Residents stated the food was satisfactory. Regular audits of the kitchen fridge/freezer temperatures and food temperatures are undertaken and documented

Outcome 1.4: Safe and Appropriate Environment

Ryman have policies and processes that determine legislation and regulatory requirements for local authorities and the Ministry of Health (MOH). Building maintenance is carried out when identified as necessary and records maintained. Health and Safety meetings include maintenance and preventative maintenance. Unfinished surfaces identified in the previous audit have been addressed. There is adequate space around the facility for storage of mobility equipment. Plant cupboards were identified as locked and hazard signs for boiler taps in the dining areas and this is an improvement since previous audit. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. The laundry and cleaning areas have hand-washing facilities. Improvements around management of laundry bags, and rubbish management have been made since previous audit and this could be described through staff interview.

Outcome 2: Restraint Minimisation and Safe Practice

There is a Restraint Minimisation Manual 2009 applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and the use of enablers. There is one enabler (lap belt) in use in the hospital and two residents requiring restraint (bedrails) in the hospital.

Outcome 3: Infection Prevention and Control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) in conjunction with the clinical services manager (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive on-going training in infection control. The findings from the certification audit relating to outbreak management, infection control training and data collection are met.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	18	0	2	1	0	0
Criteria	0	46	0	3	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	29
Criteria	0	0	0	0	0	0	0	51

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service	PA Low	Comparisons between the clinical services manager (CSM) monthly reports and the summary's generated through vCare identified	Complaint, incident and infection data is recorded and reported according to policy.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		providers and, where appropriate, consumers.		anomalies as following: a) February infections vCare: three rest home, CSM report: four rest home b) May incidents vCare 87 hospital, CSM 86 hospital. In addition there are anomalies noted in the CSM reports: a) March report records 64 hospital incidents for the month, and 84 for the previous month (February), the February report records 64 hospital incidents for the month, b) March data reports six hospital and five rest home infections for the previous month (February), the February report records five hospital and four rest home infections. During interview the CSM was aware of the number and type of incidents, infections and trending. Complaints are recorded on the register and are seen to have been investigated and closed out. Responses to complainants are on file. Meeting minutes (February 2014) report three complaints, one of which has been recorded on an incident form and appears in vCare as an incident. On the day of audit two (resident) complaints had been received and both were documented on incident forms.		
HDS(C)S.2008	Criterion 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.	PA Low	Although quality improvement plans (QIPs) are seen to be developed and signed as closed out, reporting of progress and documented evaluation of the implemented actions has not been recorded. Of 27 QIP's that were generated in April 2014, five had	Complete QIP's as prescribed including evaluation of actions taken.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				been evaluated and signed as closed. The remaining (22) had been closed out, however there was no recorded evaluation of actions taken.		
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Three of six hospital care plans (all 1st floor) reviewed identified intervention shortfalls in the care plan (noting caregivers interviewed were aware of current cares); (i) resident A - had change of mobility and this was not updated in care plan, management of continence not clearly instructed in interventions; restraint in place but restraint assessment not able to be located or interventions to manage risk were not documented (ii) resident B – care plan not reflected of current cares including SC line, bed bound/palliative care, (iii) Resident C –care plan not reflective of interventions to manage current cares including mobility status, and pressure areas. STCP in place for heel pressure areas but not for current sacral pressure areas.	Ensure care plans reflect current interventions to assist caregivers to provide support care required.	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Low	The following medication management shortfalls were identified; (i) In the hospital trolley	(i)Ensure expired medication is removed, (ii) Ensure medication that requires dating are dated,	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		there were five expired polytears, one flexitide not dated on opening; (ii) one eye drop was not dated in rest home; (iii) one medication chart identified the resident was on warfarin, advised this was actually discontinued. While the staff were not giving it, the drug chart had not been signed as discontinued, (iv) the medication signing sheet for one resident receiving eye drops was not all signed as given.	(iii) Ensure medication charts identify discontinued medication; (iv) ensure eye drops are signed for after administration	

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

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

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

Attainment and Risk: FA

Evidence:

Ryman has policies that support resident confidentiality, privacy, collection and storage of information, and access to health information (disclosure). A tour of Malvina Major confirms there is the ability to support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Resident files are stored out of sight and in locked cupboards. The finding from the previous certification audit has been met. Staff could describe definitions around abuse and neglect that align with the Ryman policy. Five relatives interviewed (three hospital, two rest home) stated that the care provided is overall good. Prevention and detection of abuse training was last delivered in May 2014 (36 staff attended). There is no evidence of abuse/neglect. An annual resident satisfaction survey was completed in December 2013. Of 34 responses received 79% rated the service as good or very good. A relative survey was sent in February 2014 and 82% responded the service was good or very good. This was an improvement on 72% the previous year. There are several married couples living at the complex and this is seen to have been incorporated into care plan documents. This finding from the previous audit has been met. Interview with a married couple confirm privacy is respected.
D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Interview with eleven caregivers (eight hospital, three rest home) describe how choice is incorporated into resident cares. Interview with 13 residents (seven rest home, four hospital and two rest home residents living in the serviced apartments') inform staff are respectful. There is an abuse and neglect policy that is being implemented and staff attend in-service education on abuse and neglect. Interviews with residents and family members were positive about the care provided.
D4.1a: Ten resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with ten residents confirm their values and beliefs were considered.
D14.4: There are instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)
Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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:

There is an incident reporting policy, and reporting forms to guide staff around the responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. 35 incident forms reviewed (28 hospital and seven rest home) identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters is available.
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 Five relatives (three hospital, two rest home) stated that they are informed when their family members health status changes.
D11.3 The information pack is available in large print and this can be read to residents.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)
Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The complaints policy and supporting documents are being implemented. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A feedback form is completed for complaints and recorded on the complaint register/s (link 1.2.3). The number of complaints received each month is reported monthly to staff via the various meetings – e.g.: caregivers, full facility, RN. There is a complaints register maintained for the care centre and includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with 13 residents (seven rest home, four hospital and two rest home residents living in the serviced apartments) and five relatives (two rest home and three hospital) confirm they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. A complainant was interviewed and reports actions being taken on the identified issue and follow-up by the village manager. The complainant was pleased with the way in which concerns were managed.
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:

Malvina Major provides care across two levels. The ground floor has 60 rest home beds, of which 20 have been assessed as suitable for dual purpose – i.e. rest home and/or hospital level. Level one has 60 hospital level beds. In addition 20 of the serviced apartments have been certified suitable for rest home level residents. On the day of audit there are 45 rest home and 12 hospital level residents (of 60) on the ground floor, 58 (of 60) hospital residents, and four rest home residents in the serviced apartments. This gives a total of 49 rest home residents (including one respite), and 70 hospital level residents.

The levels are the same layout with the upper level being accessible by lift or stairs. At the time of audit there are two rooms in both the hospital and rest home that are being refurbished, and one vacant room (rest home).

There is a documented ' purpose, values, scope, direction & goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the RAP that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities. Ryman Healthcare have operations team objectives 2014. Malvina Major has defined four key objectives for the 2014 year: excellence in palliative care, 'village with a purpose' (activities based), health and safety, and 'all about you', noting one of Malvina Major's caregivers has been named as 'caregiver of the year'. Progress towards these objectives is seen to be reported in RAP and staff meeting minutes.

The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and specialist dementia care. There is a medical component to the certificate. There is a contracted physiotherapist that works 12 hours a week and a physiotherapist assistant that works 10 hours per week. There is a contracted medical centre that provides as required services.

The village manager at Malvina Major has been in post since September 2013 and comes from a hospitality background. The village manager has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. He is supported by an assistant manager who carries out administrative functions (in post since September 2013) and a clinical services manager (RN) who oversees clinical care at the care centre. The clinical services manager has worked in a range of health care settings including aged care and district health boards. She has been in post since October 2013. The management team is supported by the Ryman management team including regional manager.

The management resource manual includes a number of documented responsibilities of the manager including a list of reporting requirements. There is a manager's job description that includes authority, accountability and responsibility including reporting requirements. The Ryman managers complete a Leadership and Management course (an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.

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: PA Low

Evidence:

Malvina Major is implementing the Ryman RAP system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP Committee, full facility and registered nurse. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.

The service has policies and procedures and the RAP programme defines systems to provide an 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. All facilities have a master copy of all policies & procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow implementation by staff. A number of core clinical practices have staff comprehension surveys that staff are required to be completed to maintain competence/knowledge and education packages which are based on their policies.

Policy and procedure review is coordinated by head office, with facility staff having the opportunity to provide feedback (staff interview). Facility staff are informed of changes/updates to policy at the various staff meetings.

Key components of the quality management system link to the RAP committee at Malvina Major who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports to that are sent to head office (Christchurch) provide a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical services manager collected across the rest home, and hospital services. However; these do not always align to the monthly total in vCare. In addition complaints have been seen to have been recorded on the Ryman incident form, and in one case entered into vCare as an incident (rather than complaint). These are areas of improvement.

The Malvina Major combined health and safety and infection control committee meet bimonthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation. There is evidence of the quality programme being reported through the various meetings that are held including complaints, incidents and trends, infections and restraint. The meeting minutes identify when quality improvement plans (QIPs) are instigated based on trends developing. The finding from the certification audit has been met.

Malvina Major is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and QIPs are completed where a noncompliance is identified and a repeat audit is required if results exceed the Ryman threshold. Issues and outcomes are reported to the appropriate committee e.g. RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – e.g. falls. The findings from the certification audit relating to the documentation of corrective action plans has been met. However, while QIPs are seen to have been closed out, evaluation of the implemented actions has not been documented and this is an area of improvement.

Weekly reporting to the regional manager includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix.

D19.3: There is a comprehensive Health & Safety and risk management programme in place. There are policies to guide practice. Malvina Major has a H&S representative recently appointed to the role (interviewed) and has completed external training.

D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist and sensor mats.

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: PA Low

Evidence:

There are monthly accident/incident reports completed by the clinical services manager collected across the rest home and hospital services, and in addition incidents are reported through vCare for organisational benchmarking and monitoring. There is evidence of the quality programme being reported through the various meetings that are held including complaints, and restraint. The meeting minutes identify when quality improvement plans are instigated based on trends developing.

The finding from the certification audit has been met.

Finding:

Comparisons between the clinical services manager (CSM) monthly reports and the summary's generated through vCare identified anomalies as following: a) February infections vCare: three rest home, CSM report: four rest home b) May incidents vCare 87 hospital, CSM 86 hospital.

In addition there are anomalies noted in the CSM reports: a) March report records 64 hospital incidents for the month, and 84 for the previous month (February), the February report records 64 hospital incidents for the month, b) March data reports six hospital and five rest home infections for the previous month (February), the February report records five hospital and four rest home infections. During interview the CSM was aware of the number and type of incidents, infections and trending.

Complaints are recorded on the register and are seen to have been investigated and closed out. Responses to complainants are on file. Meeting minutes (February 2014) report three complaints, one of which has been recorded on an incident form and appears in vCare as an incident. On the day of audit two (resident) complaints had been received and both were documented on incident forms.

Corrective Action:

Complaint, incident and infection data is recorded and reported according to policy.

Timeframe (days): 90 *(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: PA Low

Evidence:

Malvina Major is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified and a repeat audit is required if results exceed the Ryman threshold (90%). Issues and outcomes are reported to the appropriate committee e.g. RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – e.g. falls. The finding from the certification audit relating to corrective action planning has been met.

While QIPs are seen to have been closed out, evaluation of the implemented actions has not been documented and this is an area of improvement.

Finding:

Although QIPs are seen to be developed and signed as closed out, reporting of progress and documented evaluation of the implemented actions has not been recorded. Of 27 QIP's that were generated in April 2014, five had been evaluated and signed as closed. The remaining (22) had been closed out, however there was no recorded evaluation of actions taken.

Corrective Action:

Complete QIP's as prescribed including evaluation of actions taken.

Timeframe (days): 90 *(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:

D19.3c: The service collects incident and accident data. 35 incident forms were reviewed in files audited that included 28 relating to hospital residents and seven rest home residents. The forms reviewed were completed as prescribed and signed out.
D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. QIPs were cited for incidents above the benchmark for example falls and skin tears (link 1.2.3).
Discussions with the village manager, assistant manager and clinical services manager, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications and the finding from the certification audit is now closed.

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:

The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Relevant documentation is seen in nine staff files reviewed (one activities coordinator who is also the health and safety rep, one registered nurse who works night duty, two registered nurse coordinators (hospital and rest home) – one of which is the infection control coordinator, serviced apartment coordinator (enrolled nurse), kitchen hand and three caregivers).). Additional role descriptions are in place for infection control coordinator, restraint coordinator, in-service educator, health and safety officer, fire officer and quality assistant.

In three of the nine files the performance appraisal was overdue for review. The samples size was extended to an additional five files and all had current appraisals. The village manager, assistant village manager and clinical services manager either complete or oversee the appraisal process and interview with this team demonstrates a plan is in place to complete any outstanding appraisals. The finding from the certification audit relating to appraisals is considered to have been met.

Policy: Health practitioners and competencies outline the requirements for validating professional competencies. A register of practising certificates is maintained. Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering.

There is a 2014 training plan developed for Malvina Major that is aligned with the RAP, and includes opportunistic in-service based on clinical matters occurring at the facility. Staff education and training includes the ACE programme for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly at all Ryman facilities and subjects covered include (but not limited to) warfarin and wound management. Six RN's interviewed (four hospital and two rest home) spoke positively about the journal club.

Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on. Efforts have been made to improve rates of attendance at in-service training with varied effect, however there has been success with completion of the prescribed 'staff comprehension surveys'. Interview with the assistant manager and clinical services manager inform group sessions are run and questions answered collaboratively. These sessions have effectively become in-service opportunities. The following results are recorded: survey number one incudes but not limited to:

complaints, resident rights, abuse, values – completed by 120 staff; survey number two includes: medication infection control, wounds, - completed by 60; survey numbers five (RN/EN medications), and three (food services) were both completed by the required number of staff. There is access to external training for staff – e.g. the palliative care series – and some internal opportunistic sessions are seen to have been provided by external specialists. For example on the day of audit the infection control regional meeting was being hosted at Malvina Major and the clinical services manager and several RN's attended. Based on the evidence reviewed, the finding relating to training and RN professional development is considered to have been met.

Ryman has a 'Duty Leadership' training initiative that all RNs, ENs and Senior Leaders complete. It includes four modules/assignments around resident rights, customer service, leading colleagues and key operations/situations.

The clinical structure in the facility includes a clinical services manager, registered nurse coordinators in each service area (rest home and hospital) and a team of registered nurses and care staff. The serviced apartments (where there is currently four rest home level residents) have a coordinator. At the time of audit the rest home coordinator was to be appointed. The position was being covered by one of the RN's.

Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff and actively support the Health Ed Trust ACE Programmes and provide incentives to their staff to undertake both the general and dementia modules. Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme. There is an ACE assessor at Malvina Major who is a registered nurse and works 17.5 hours per week (interviewed).

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:

Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Interview with 11 caregivers (eight hospital and three rest home), two coordinators (hospital and rest home) and six registered nurses (four hospital, two rest home) including one that works night duty, confirm overall the staffing levels are appropriate to meet the needs of the residents. Residents 13 (seven rest home, four hospital and two rest home residents who live in serviced apartments) and five family members (two rest home and three hospital) interviewed state there are sufficient staff on duty to meet their needs. There is a designated registered nurse coordinator for the rest home and one for the hospital. The management team report a low staff turnover, with those that have left have been planned. The rest home coordinator is acting at the time of audit, with a new appointment pending. There is evidence the number of staff are increased to reflect the needs of residents – such as the recent use of a 'special'. The service has a casual pool of approximately 14 caregivers, two enrolled nurses and four registered nurses who are called to cover unexpected absence on the floor. Review of one month's roster (June) shows unexpected absences have been covered in all instances. The clinical services manager (RN) works on the floor one shift per week, this assists in supporting and mentoring new staff.

The following rosters are implemented:

Hospital (58 residents occupying 60 beds): am: RN coordinator, three RN's, 12 caregivers, a caregiver 0900-1600 in the lounge and a fluid assistant three hours; pm: three RN's, nine caregivers, and a caregiver in the lounge; night: one RN and three caregivers.

Rest home (12 hospital and 45 rest home residents occupying 60 beds): am: RN coordinator, one RN, eight caregivers; pm: one RN, 7 caregivers; night: one RN, three caregivers.

Serviced apartments (4 at rest home level): am: coordinator (either EN or senior caregiver) and three caregivers; pm: 2 caregivers and one 4.30-8.30pm to assist with tea. The registered nurse in the rest home covers the serviced apartments at night.

The village manager and clinical services manager are on call. There are four activity coordinators.

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:

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; The initial admission assessments and plans and long term care plan were completed by the registered nurses within a three week timeframe in all ten resident files reviewed which included four rest home (including one serviced apartment and one respite), and six hospital. The care plan is reviewed by the registered nurses and amended when current health changes. Evaluation is completed within six months. Eight of 10 resident files evidence six month evaluations (one was a respite resident and one was a newer admission).

D16.5e; Medical assessments were documented in all ten resident files within 48 hours of admission. One- three monthly medical reviews were documented in the resident files by general practitioners. More frequent medical assessment/ review noted occurring in residents with acute conditions and those requiring palliative care.

Two GPs involved with the service were interviewed and identified positive feedback and on the clinical care, oversight and support provided by staff.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. A serviced apartment coordinator who is and enrolled nurse is responsible for residents in the services apartments which further clinical oversight provided by the rest home coordinator (RN) and clinical manager. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. All ten files reviewed evidence this is occurring. The physiotherapist visits 2x weekly and a physiotherapy assistant provides physiotherapy five days a week as directed by the physiotherapist.

Hourly monitoring charts are completed by caregivers for a number of residents on both floors. These were up to date.

Wound care folders evidenced kept in all three areas and assessments are signed by a registered nurse. Activity assessments and activities care plans have been completed by the activity therapists.

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: PA Moderate

Evidence:

There is a long term nursing care plan (vCare) that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality.

Each area of the care plan includes: problems/needs, objectives and interventions. Eight of eleven files (six hospital, five rest home) reviewed reflected current needs.

A shortened 'nursing care assessment and careplan' was in place for the respite resident and included current interventions.

Two residents with identified behaviours that challenge (one hospital and one rest home) identified behaviour assessments and care plans and this is an improvement on previous audit.

Four residents (one rest home, three hospital) had identified weight loss and all had short term care plans (STCP)s in place which included interventions. Food/fluid charts were sighted to be in use.

Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist and dietitian's. Resident medications and medical status are reviewed one- three monthly by the General Practitioners. The GPs interviewed stated they visit at least 2x weekly or more frequently as required. Activity therapists maintain activity assessment/care plans and evaluation in residents file. There are specific physiotherapy progress notes. There is a link between physiotherapy notes and the care plan.

D16.3k Short term care plans are in use for changes in health status.

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: PA Moderate

Evidence:

Seven of ten care plans (four rest home, three hospital) reviewed described the required support and/or interventions to achieve the desired out comes identified by the on-going assessment process. Clinical assessments have been completed for all 10 residents and these are routinely completed six monthly.

Finding:

Three of six hospital care plans (all 1st floor) reviewed identified intervention shortfalls in the care plan (noting caregivers interviewed were aware of current cares); (i) resident A - had change of mobility and this was not updated in care plan, management of continence not clearly instructed in interventions; restraint in place but restraint assessment not able to be located or interventions to manage risk were not documented (ii) resident B – care plan not reflected of current cares including SC line, bed bound/palliative care, (iii) Resident C –care plan not reflective of interventions to manage current cares including mobility status, and pressure areas. STCP in place for heel pressure areas but not for current sacral pressure areas.

Corrective Action:

Ensure care plans reflect current interventions to assist caregivers to provide support care required.

Timeframe (days): 60 *(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:

Ten resident files were reviewed four rest home (including one rest home resident in serviced apartments and one respite) and six hospital.

Two wound folders were reviewed for each floor. Wounds reviewed included; seven ulcers, five pressure areas sacrum, two heel pressure areas, and three skin tears wounds being treated. All evidenced a wound care assessment and treatment plan including evaluation completed and reviewed by an RN. Overall pressure areas reviewed linked to STCPs or LTCPs (link 1.3.5.2).

Appropriate pressure relieving equipment and strategies are in place. Including pressure relieving mattress, review of nutritional assessment and frequent changes of position. Interviews with six registered nurses (one night RN, two rest home, three hospital) described current primary nursing approach, documentation, wound management and communication. Handover between shifts was observed. Monitoring charts are regularly in use including ensuring 30 mins checks of residents.

D18.3 and 4 Dressing supplies are available and a treatment rooms in each area are 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.

The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.

Seven of ten care plans reviewed included interventions consistent with meeting the residents assessed needs (link 1.3.5.2).

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 a team of activity coordinators within the facility, comprising two rest home staff employed 40 hours and 20 hours Monday to Friday. Working in the hospital, one who works forty hours weekly Monday to Friday, one working Saturday and Sunday employed for six hours, an assistant who works Monday to Friday 2.00-4.30. Additionally to help the hospital activity coordinators is a lounge assistant who helps with any resident needing attention such as toileting during the activities, working Monday to Friday 9.30-4.30.

In the serviced apartments, a coordinator works full time Monday to Friday who also supports the activities of the four rest home residents. Their employment ranges from 4 months to 9.5 years, all having a first aid certificate. Also employed at the facility is a dedicated bus driver who drives the van for resident trips. They meet regularly to plan for future activities within the activity standards set out by Ryman's, including the "triple A" exercise activity. The activity coordinators complete a weekly programme for all areas based on the needs of the resident's interest. Links are maintained with the community with visiting entertainers, local schools and colleges, and monthly speakers. Ryman residents spiritual needs are met with inter-denominational church services weekly and visiting Salvation Army groups. There is a full programme for residents including quizzes, crafts walking groups, bowls, housie, movies, happy hour and music. The programmes are flexible to meet the recreational preferences of the residents. Outings are scheduled using the company van with wheelchair access. All residents are invited to all themed activities and functions including a monthly "fine dining", Anzac day, wearable arts, winter solstice and sporting celebrations. There are resident initiated groups including music, reading, majong and more recently herb growing for those who are more independent.

Resident meetings are held monthly, providing feedback and suggestions to the activity programme. Residents interviewed on the day of the audit are very satisfied with the content and variety of the activity programmes and state that is has improved greatly. There is an activity assessment for each new resident from which an activity plan is developed. This is evaluated and reviewed every six months and linked with the long term care plan. There are activity plans in place for the rest home residents living in the serviced apartments. The activity coordinators all describe having regular contact with family/whanau. There is an activity assessment and plan for each new resident which includes previous hobbies, community links family and interests. Resident files sampled were evaluated and reviewed every six months and linked with the long term 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 Vcare evaluation template describes progress against every goal and need identified in the care plan. Short term care plans are well utilised. Short term care plans were evidenced completed for wounds, pressure areas, Urinary Tract Infections, increased confusion, weight loss, and infections (also link 1.3.5.2). This is an improvement on the previous audit. Any changes to the long term care plan are dated and signed. Care plans reviewed included handwritten updates to the plan as needs have changed.

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

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

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 an RN across all areas. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies are on all medication charts reviewed.

Medication administration was observed in the hospital, and rest home. Medications and associated documentation is kept in the locked medication trolley in all areas including the serviced apartments. Medication trolleys are stored in locked treatment rooms when not in use.

RN's in the hospital and senior caregivers/RN in the rest home and serviced apartments 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 a locked treatment room on each floor. 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 in each area.

All senior caregivers/RNs/ENs administering medication complete a medication package. An annual medication administration competency is completed of each staff member. These are up to date.

There is a self-medicating resident's policy in place. A self-medication assessment checklist is available and has been completed and reviewed for one resident in the rest home self-administering (last reviewed Jan 2014).

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.

D16.5.e.i.2; Twenty two medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

The following medication management shortfalls were identified; (i) In the hospital trolley there were five expired polytears, one flexitide not dated on opening; (ii) one eye drop was not dated in rest home; (iii) one medication chart identified the resident was on warfarin, advised this was actually discontinued. While the staff were not giving it, the drug chart had not been signed as discontinued, (iv) the medication signing sheet for one resident receiving eye drops was not all signed as given.

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 a registered nurse (RN) across all areas. Medication charts record prescribed medications by residents' general practitioner, including PRN and short course medications. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies are on all medication charts reviewed

Finding:

The following medication management shortfalls were identified; (i) In the hospital trolley there were five expired polytears, one flexitide not dated on opening; (ii) one eye drop was not dated in rest home; (iii) one medication chart identified the resident was on warfarin, advised this was actually discontinued. While the staff were not giving it, the drug chart had not been signed as discontinued, (iv) the medication signing sheet for one resident receiving eye drops was not all signed as given.

Corrective Action:

(i)Ensure expired medication is removed, (ii) Ensure medication that requires dating are dated, (iii) Ensure medication charts identify discontinued medication; (iv) ensure eye drops are signed for after administration

Timeframe (days): 30 *(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 are food policies/procedures for food services and menu planning appropriate for this type of service. There are two qualified cooks and one chef who oversee the facility food service, ordering of food items, staffing and assisted by three kitchen hands. The menu is six weekly rotating summer and winter. This is reviewed by a qualified

dietitian yearly who reports any recommendations. The RN provides a resident's nutritional profile on admission, informing the chef or cooks of any dietary preferences, including likes and dislikes. Dietary needs include vegetarian, diabetic, gluten free and soft/pureed including religious (Jewish) preferences. There are specialised lip plates and utensils as required to promote resident independence at meal times. The main meal is at midday. Meals are serviced from Bain Marie's in the hospital, rest home and serviced apartment rest home. The kitchen is well equipped with adequate pantry and dry goods storage space. Resident files reviewed included the nutrition assessment in line with the care plan review. Copies are provided to the kitchen, with special diets including dislikes are written on the kitchen whiteboard for quick reference. Regular monitoring of resident's weight and nutritional needs occur. Fridge and freezer temperatures are recorded daily, and there was evidence that a freezer showing recordings outside of the acceptable range was promptly repaired. All perishable goods in the fridges are all date labelled and stored above floor level. Staff were observed wearing correct protective wear, hats, gloves and aprons. There are cleaning schedules in place. Ecolab provide the chemicals, safety data sheets and provide chemical safety training as required. Chemicals are stored safely in a locked room within the kitchen. The chef, cooks and two kitchen hands have completed food safety training, with one kitchen hand working towards completion. There was evidence of a quality improvement initiative with the pureed/soft foods improving the taste and presentation. Nine rest home residents and two hospital residents interviewed spoke favourable about the food and variety.

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:

Ryman have policies and processes that determine legislation and regulatory requirements for local authorities and the MOH. Building maintenance is carried out when identified as necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 20 November 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2014. Hot water temperatures were sighted and were below 45 degrees.

Health and Safety meetings include maintenance and preventative maintenance. Unfinished surfaces identified in the previous audit have been addressed. There is adequate space around the facility for storage of mobility equipment.

Plant cupboards were identified as locked and hazard signs for boiler taps in the dining areas and this is an improvement since previous audit.

D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, hoists, 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.)*

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

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

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

Attainment and Risk: FA

Evidence:

The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. The laundry and cleaning areas have hand-washing facilities. Improvements around management of laundry bags, and rubbish management have been made since previous audit and this could be described through staff interview.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There is a Restraint Minimisation Manual 2009 applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and the use of enablers. There is one enabler (lap belt) in use in the hospital and two residents requiring restraint (bedrails) in the hospital. One enabler file and restraint file reviewed included consents (link 1.3.5.2). Training has been provided to staff around challenging behaviour.

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 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description. There is an implemented infection control programme that is linked into the quality management system (link 1.2.3). Infection control matters are integrated with the bimonthly health and safety meetings and which includes a cross section of staff. The facility meetings – RAP committee, registered nurse, full facility, management - also include a discussion and reporting of infection control matters. Information from these meetings is passed onto the staff meetings. The IC programme policy states that the IC programme is set out annually from head office and is directed via the RAP annual calendar. The annual review policy states IC is an agenda item on the two monthly head office health and safety committee. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB.

Interview with the infection control coordinator (rest home coordinator – RN) and the clinical services manager inform there has been no outbreak since the 2013 norovirus. Both were able to describe authorities that would be contacted and the process to follow should an outbreak be suspected. The residents in the serviced apartments are also monitored for potential infections. Hand washing is part of the internal audit programme – April 2014, 100% compliance – and in-service around outbreak management has been provided. Based on the interviews, and appreciating the service has not had an outbreak since norovirus, the finding from the certification audit is considered to be met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)
The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)
Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)
The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control officer (in conjunction with the clinical service manager) is responsible for coordinating/providing education and training to staff. The IC officer is a registered nurse who is currently the acting rest home coordinator. The rest home coordinator will continue in the role of infection control officer once appointed. This position is supported by the clinical services manager. The acting rest home coordinator has completed a post graduate diploma in infection control and prevention (2013) and the

clinical services manager has completed the MoH online learning package. The regional infection control meeting was held at Malvina Major on the day of audit the IC officer, CSM and a number of registered nurses attended. The induction package includes specific training around hand washing and standard precautions and the CSM and RN (i.e. IC officer) confirm the IC officer provides training both at orientation and on-going. Training on outbreak management has been provided in September 2013 (49 attended) attended, outbreak and infection control for housekeeping in January (2014) and six attended, and a session for staff last provided in May 2014. The all staff comprehension survey (number 2) includes infection control and was completed by 60 staff.

Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. Residents (seven rest home, four hospital and two rest home residents who live in the serviced apartments) and relatives (two rest home and three hospital) were aware of infection control precautions such as hand washing. There are notices at the front of the building with hand sanitisers.

Based on the evidence reviewed the findings from the certification audit relating to staff and resident and relative interviews are consider to be met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the clinical services manager (link 1.2.3). Infection control data is collated monthly and reported to the combined infection control and health and safety bimonthly meetings. QIPs are seen to be developed when trends are identified (link 1.2.3). Staff are informed through the variety of meetings held at the facility (minutes sighted), trending is discussed.

The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the RAP. The results are subsequently included in the village manager's report. Internal infection control audits also assist the service in evaluating infection control needs (handwashing last completed April 100% compliance, environment audit completed February 100% compliance). As well as scheduled in-service the IC officer and clinical services manager inform opportunistic education is provided during hand over as required.

There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Interview with the infection control coordinator and clinical services manager inform sufficient PPE is available and at the time of audit there are no residents in isolation. There have been no outbreaks since the 2013 event.

The finding from the certification audit relating to infection trending and reporting in meeting minutes is considered to be met.

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.)*