# Beckenham Courts Retirement Village Limited

## Current Status: 13 August 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Partial Provisional 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

Beckenham Courts is a Ryman Healthcare facility, situated in Christchurch. A newly purpose-built facility has been built and attached to part of the current facility. The new facility is modern, spacious and extends across three levels. Level one was opened in June 2014 and level two opened 8th August. Level two (second level) includes a 41 bed wing that will provide care for hospital residents (dual purpose) and level three includes a 24 bed dementia unit. These areas were assessed as part of this partial provisional audit.

The new building has a total of 125 beds; including 30 certified serviced apartments across level one and two that have been assessed as suitable to provide rest home level care. The facility currently has 29 residents on the ground floor including 28 rest home and one hospital resident. There are also six rest home residents from the serviced apartments currently living on the second floor while their serviced apartments are being re-furbished.

The village manager (RN) is an experienced aged care manager. She is supported by a newly appointed clinical manager (RN).

The audit identified the facility, staff roster and equipment requirements and processes are appropriate for providing rest home, hospital – geriatric/medical and dementia level care and in meeting the needs of the residents.

The corrective actions required by the service are all related to the completion of the building.

# 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:** | Beckenham Courts Retirement Village Limited |
| **Certificate name:** | Beckenham Courts Retirement Village Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Partial Provisional Audit | | | |
| **Premises audited:** | Beckenham Courts Retirement Village | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care) | | | |
| **Dates of audit:** | **Start date:** | 13 August 2014 | **End date:** | 13 August 2014 |

**Proposed changes to current services (if any):**

A newly purpose-built facility has been built and attached to part of the current facility. Level one was opened in June 2014 and level two opened 8th August. The new facility is modern, spacious and extends across three levels. Level two (second level) includes a 41 bed wing that will provide care for hospital residents (dual purpose) and level three includes a 24 bed dementia unit. A further 10 serviced apartments were also assessed as suitable to provide rest home level care should they be provided. These areas were assessed as part of this partial provisional audit.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 35 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXXX | **Hours on site** | 3 | **Hours off site** | 3 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 3 | Total audit hours off site | 4 | Total audit hours | 7 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed |  | Number of managers interviewed | 2 |
| Number of residents’ records reviewed |  | Number of staff records reviewed | 1 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed |  | Total number of staff (headcount) | 39 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology |  |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXXXXX, 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 | Not Applicable |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Tuesday, 19 August 2014

## **Executive Summary of Audit**

**General Overview**

Beckenham Courts is a Ryman Healthcare facility, situated in Christchurch. A newly purpose-built facility has been built and attached to part of the current facility. The new facility is modern, spacious and extends across three levels. Level one was opened in June 2014 and level two opened 8th August. Level two (second level) includes a 41 bed wing that will provide care for hospital residents (dual purpose) and level three includes a 24 bed dementia unit. These areas were assessed as part of this partial provisional audit.

The new building has a total of 125 beds; including 30 certified serviced apartments across level one and two that have been assessed as suitable to provide rest home level care. The facility currently has 29 residents on the ground floor including 28 rest home and one hospital resident. There are also six rest home residents from the serviced apartments currently living on the second floor while their serviced apartments are being re-furbished.

The village manager (registered nurse [RN]) is an experienced aged care manager. She is supported by a newly appointed clinical manager (RN).

The audit identified the facility, staff roster and equipment requirements and processes are appropriate for providing rest home, hospital – geriatric/medical and dementia level care and in meeting the needs of the residents.

The corrective actions required by the service are all related to the completion of the building.

**Outcome 1.2: Organisational Management**

The organisation completes annual planning and has comprehensive policies/procedures to provide rest home, hospital, (medical and geriatric) and dementia care. The staff and newly purpose-built facility are appropriate for providing these services and in meeting the needs of residents.

There are documented job descriptions for all positions which detail each position’s responsibilities, accountabilities and authorities. Organisational human resource policies are implemented for recruitment, selection and appointment of staff. The organisation has a well-established induction/orientation programme which includes packages specifically tailored to the position such as caregiver, senior caregiver, RN, and so on. There is a 2013/14 training plan implemented at Beckenham.

Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents and rosters are in place and is adjustable depending on resident numbers. The draft roster's and processes around employment of new staff are in place for each floor. The service is providing 24 hour registered nurse cover since opening of the ground floor.

**Outcome 1.3: Continuum of Service Delivery**

The medication management system includes Medication Policy and Procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. All senior staff have current medication competencies. There are medication treatment rooms on each floor. There is an improvement required around the completion of the medication room on level three.

There is a large workable kitchen in a service area off the care centre on the ground floor. There is a walk-in chiller and pantry. The menu is designed and reviewed by a Registered Dietitian at an organisational level. Food is to be transported in food carriers to the kitchenettes on each floor. All residents have a nutritional profile completed on admission which is provided to the kitchen.

**Outcome 1.4: Safe and Appropriate Environment**

The service has waste management policies and procedures for the safe disposal and management of waste and hazardous substances. There is appropriate protective equipment and clothing for staff.

There are handrails in ensuites and hallways. The service has purchased all new equipment, and furniture including (but not limited to), hoists, pressure relieving mattress's and mobility equipment. Level three is still being furbished and therefore the certificate for public use has not yet been signed off for level three. The balcony and landscaping of the external areas on level three is yet to be completed.

All bedrooms have en-suites and there is communal toilets which are easily accessible from communal areas. Fixtures, fittings and floor and wall surfaces in bathrooms and toilets are made of accepted materials for this environment.

Resident rooms are of sufficient space to ensure care and support to all residents and for the safe use of mobility aids.

The communal areas on each floor are well designed and spacious and allow for a number of activities.

The Ryman group has robust housekeeping and laundry policies and procedures in place. There is a large laundry in the service area including a separate clean linen and sorting room. The facility has a secure area for the storage of cleaning and laundry chemicals. Laundry and cleaning processes are monitored for effectiveness in the new laundry.

The Ryman group emergency and disaster manual includes (but not limited to) dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. The fire evacuation plan is in draft and a requirement of the CPU.

General living areas and resident rooms are appropriately heated and ventilated, all rooms have windows.

**Outcome 3: Infection Prevention and Control**

There are clear lines of accountability to report to the IC team on any infection control issues including a Reporting and Notification to Head Office policy. As per Ryman policy, the Infection Control team is integrated as part of the two monthly IC/H&S meeting. Monthly collation tables are to be forwarded to Ryman Head office for analysis and benchmarking. Infection control is an agenda item in the monthly staff meeting.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 12 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 31 | 0 | 4 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 66 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The treatment room on level three (dementia unit) is not yet completed. | Ensure the treatment room on level three is lockable and fully furbished. | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.4.1: Management Of Waste And Hazardous Substances | Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.1.1 | Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | Currently the sluice room door on level three has a key lock and is not practical for all staff. | Ensure the sluice room door includes a practical lock for staff | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | Level three is in the process of being completed and therefore the certificate for public use has not yet been signed off. | A Certificate of Public Use (CPU) must be sighted by DHB/healthcert prior to opening | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | The balcony off the dementia unit is in the process of being completed/landscaped. | Ensure there is safe external areas for residents to access. | Prior to occupancy |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **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:**

A newly purpose-built facility has been built and attached to part of the old Beckenham Courts facility. The new facility is modern, spacious and extends across three levels. Level one (ground level) includes a 30 bed wing that provides care for rest home and hospital residents and the main service areas for the facility. These areas were opened June 2014. The facility currently has 29 residents on the ground floor including 28 rest home and one hospital resident. There are also six rest home residents from the serviced apartments currently living on the second floor while their serviced apartments are re-furbished.

The new building has a total of 125 beds; including a 30 bed rest home/hospital unit on level one, a 41 bed hospital unit on level two, 24 bed dementia unit on level three and a further 10 serviced apartments were also assessed as suitable to provide rest home level care should they be required (total of 30 certified apartments across level one and two).

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.

Each service also has their own specific RAP project/objectives and for Beckenham Courts in 2014 this includes; a) Reduce falls rates, b) Management of hazards within an on-going construction site, c) The successful transition to the new facility, d) Rebuilding staff team and e) to ensure successful opening of the special care unit.

The organisation completes annual planning and has comprehensive policies/procedures to provide rest home care, hospital care and specialist dementia care.

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 Manager's complete a Leadership and Management courses (an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.

The village manager (RN) maintains an annual practicing certificate and attends professional development and clinical education each year. The nurse manager has attended in excess of eight hours of professional development in the past 12 months including the Ryman manager’s conference, seminars on human resource management and managing adverse events. She has been in the role for over seven years.

A clinical manager has commenced (experienced aged care RN). She has been receiving orientation to the role working alongside an experienced Clinical manager at another Ryman village.

##### **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 1.2.2: Service Management **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

**Attainment and Risk:** FA

**Evidence:**

The clinical manager (RN) fulfils the manager role during a temporary absence with support by the regional manager (RN). The organisation completes annual planning and has comprehensive policies/procedures to provide rest home care, and hospital care. The staff and newly purpose-built facility are appropriate for providing rest home, hospital/medical, and dementia and in meeting the needs of residents.

The service has a house GP that visits 2x weekly and as required. A physiotherapist is currently being contracted 12 hours a week.

##### **Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)**

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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. Additional role descriptions are in place for infection control coordinator, Liverpool care pathway coordinator, restraint coordinator, in-service educator, health and safety officer, fire officer and quality assistant.

Policy: Health practitioners and competencies outline the requirements for validating professional competencies. Copies of practising certificates are obtained.

Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios, rostering etc.

The manager advised that there are currently four employed registered nurses that have completed the Ryman orientation pack. The service is in the process of employing more caregivers. There are currently enough caregivers to cover the new hospital and dementia unit initially. They have completed orientation. Many of the Beckenham caregivers have been working in other Ryman facilities (including hospital units) in Christchurch while the new facility has been built.

There is a 2013/14 training plan developed for Beckenham has been implemented. The training programme includes; (but not limited to) key clinical sessions such as continence, pain management, wound care, manual handling, medication management and de-escalation techniques.

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 meets two monthly and subjects covered include (but not limited to) warfarin, wound management, Liverpool care pathway etc. 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.

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.

E4.5f: There has been a new RN coordinator appointed to the special care unit from another Ryman facility. There are currently two caregivers on the dementia unit roster that have completed dementia standards. Advised that all newly employed caregivers employed for the dementia unit will be supported to complete the dementia standards within the first year. There is a Ryman educator employed one day a week to support caregivers to complete required standards.

##### **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:**

Determining Staffing Levels and Skills Mix Policy 2.8.1 provides the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Ryman has developed a number of draft rosters for increase in resident numbers across new facilities.

A draft roster has been developed for each area and is adjusted as resident numbers increase.

Dementia unit. (24 beds)

1 RN coordinator Sun – Thurs 0730 – 1600

1x caregiver 0700 - 1530

1x caregiver 0700 - 1500

1x caregiver 0800 – 1300

PM

2x caregivers 1500 - 2300

2x caregiver 1600 – 2000

N

2x caregivers 2245 – 0715 and 2300 - 0700

Hospital (41 residents)

AM

clinical manager/RN 0730-1630

2x RN 0700-1530

2x caregiver 0700 - 1530

2x caregiver 0700 - 1500

4x caregiver 0700 - 1300

Fluid carer 0930 - 1230

PM

2x RN 1500 – 2330

2x caregivers 1500 - 2300

2x caregivers 1500 – 2100

2x caregivers 1600 – 2100

1x lounge carer 1600 - 2000

N

1 x RN 2300 - 0715

3x caregivers 2300 – 0700

Physio assistant 0900 – 1200

There is a roster to cover the serviced apartments that includes

SA coordinator 0700 – 1530

1 x caregiver 0730 – 1400

1 x caregiver 0730 – 1300

1 x caregiver 1630 – 2100

1 x caregiver 1630 – 2000

From 2000 hrs. the service apartments are covered by staff in the rest home/hospital.

Currently serviced apartment residents (including the six rest home residents) are occupying level two hospital wing while their serviced apartments are being re-furbished. A roster was sighted.

##### **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 1.3.12: 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 organisations Clinical Services Manual includes a range of medication policies.

The service uses four weekly blister packs as per Ryman policy. The service uses four weekly blister packs as per Ryman policy. The treatment room on level one is now fully functioning and includes keypad lock, CD safe and medication fridge. This is an improvement on previous partial provisional. The treatment room on level 2 (hospital) is fully completed and ready for use. Advised that a CD safe is to be installed in this treatment room as well as on level three. There are new lockable medication trolleys for each floor.

A Self-Medicating Residents Policy is available if required. This process is well established throughout Ryman services. Locked drawers are provided in resident rooms.

The Ryman policies identify that medication errors are treated as an incident and captured as part of the incident management system and a medication error analysis is to be completed.

Medicine management information is fully established at Beckenham Courts on level one. Policies and procedures reflect medication legislation and the safe management of medicines- a guide for managers of old people’s homes and residential care facilities and D 16.5 and D19.2. Advised that only those deemed competent are responsible for administration of medication. Senior caregivers have completed medication competencies annually and a register is maintained. Registered nurses also complete competencies and those currently employed have up to date competencies.

##### **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 four weekly blister packs as per Ryman policy. The treatment room on level one is now fully functioning and includes keypad lock, CD safe and medication fridge. This is an improvement on previous partial provisional. The treatment room on level 2 (hospital) is fully completed and ready for use. Advised that a CD safe is to be installed in this treatment room as well as on level three. There are new lockable medication trolleys for each floor.

**Finding:**

The treatment room on level three (dementia unit) is not yet completed.

**Corrective Action:**

Ensure the treatment room on level three is lockable and fully furbished.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene and infection control and special diets.

The new building has a large workable kitchen in a service area off the rest home wing. There is a walk-in chiller and pantry.

The menu is designed and reviewed by a Registered Dietitian at an organisational level.

Food is transported in food carriers to the kitchenette in the main dining room and also the serviced apartment dining room on level one. Meals are served to residents from the bain maries in the kitchenettes. The hot water is behind a locked cupboard in the kitchenettes. This process is to be fully implemented on level two and three.

There are two chiefs (food safety certs completed) and two kitchen assistants.

Ryman has an organisational process whereby all residents have a nutritional profile completed on admission which is provided to the kitchen. There is access to a community dietitian.

Regular audits of the kitchen fridge/freezer temperatures and food temperatures are undertaken and documented as part of the RAP programme. Daily chiller, freezer and meal temperatures were sighted. Nutritional profiles were available in the kitchen in regards to residents currently living on level one.

##### **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 1.4.1: Management Of Waste And Hazardous Substances **(**HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

**Attainment and Risk:** PA Low

**Evidence:**

There are documented processes for Waste Management. This includes Waste Management - General Waste Policy, Waste Management - Medical Waste Policy and Waste Management - Sharps Policy. The policies document procedures for the safe and appropriate storage, management, use and control and disposal of waste and hazardous substances. There is a locked cleaner’s cupboard and a sluice with lockable cupboards.

Waste management audit are part of the RAP programme.

All staff are required to complete training regarding the management of waste during induction. Chemical safety training is a component of the compulsory two yearly training and orientation training. All new staff will complete waste management training and PPE at orientation through the employees induction programme. Gloves, aprons, and goggles have been purchased and to be installed in the sluice and cleaners cupboards (level one and two already stocked for use). Infection control policies state specific tasks and duties for which protective equipment is to be worn.

##### **Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)**

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

**Attainment and Risk:** PA Low

**Evidence:**

All staff are required to complete training regarding the management of waste during induction. Chemical safety training is a component of the compulsory two yearly training and orientation training. All new staff will complete waste management training and PPE at orientation through the employees induction programme. Gloves, aprons, and goggles have been purchased and to be installed in the sluice and cleaners cupboards (level one and two already stocked for use).

**Finding:**

Currently the sluice room door on level three has a key lock and is not practical for all staff.

**Corrective Action:**

Ensure the sluice room door includes a practical lock for staff

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

##### **Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)**

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### 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:** PA Low

**Evidence:**

The facility is purpose built and the design modelled on previously opened Ryman facilities. The facility is near completion. All building and plant have been built to comply to legislation. The organisation has purchased all new equipment for the Beckenham facility.

Residents are able to bring their own possessions into the home and are able to adorn their room as desired. The maintenance schedule includes checking of equipment. The organisation has purchased all new equipment, and furniture.

All electrical equipment and other machinery is checked as part of the annual maintenance and verification checks. Medical equipment Calibration and Servicing is captured within the RAP programme and scheduled annually. This process is well established at Beckenham. Ryman researches appropriate equipment and furniture for this type of setting and the needs of the residents.

Policies relating to provision of equipment, furniture and amenities are documented in section 4.2 of the Management Resource Manual.

A monitoring programme is available in each bedroom and ensuite to ensure the resident is effectively monitored with dignity and limited interruption. The system includes sensor bed mats that activate the lights in resident rooms, so when a resident gets up at night the light in their en-suite automatically turns on, this prompts the resident to go to the toilet and then on leaving the ensuite the light above the resident’s bed illuminates and encourages the resident to go back to bed.. This system is controlled by a timer and therefore can be set to meet the needs of individual needs of each resident. The door to each bedroom is also reed switched and should the resident open their door at night (or after their sensor system has been set) the alarm activates on the staff members pager. This way the staff member is alerted to which residents are up and wandering. There is also nurse presence bell, when a nurse/carer is in the resident room a green light shows staff outside that a colleague is in a particular room

The new building is divided into three levels. Level one (ground level) is open and contains a 30 bed care centre that provides care for rest home and hospital residents and the main service areas for the facility. There are currently 28 rest home residents and one hospital resident.

There are a number of landing strips, hoists purchased and sensor mats. There are handrails in en-suites and hallways. All rooms and communal areas allow for safe use of mobility equipment. The building has carpet with vinyl/tiled surfaces in bathrooms/toilets and kitchen area. There is adequate space in the new facility for storage of mobility equipment.

There is a Building WOF dated 1/7/14. A certificate of Public Use has been obtained for level one and two 6/8/14. Level three is yet to be signed off.

The dementia unit on level three has a centrally located nurse station directly off the open plan aspect of the dining and lounge areas, ensures that staff are in close contact with residents even when attending to paper work or meetings. The dementia unit has been specifically designed and purpose-built by Ryman’s in-house development team. This team also keeps track of international research to ensure appropriate and effective design and flow of these specialised units. Also the designs are a reflection of resident, relative and staff feedback from other Ryman dementia units.

The unit connects via a secure entrance to the floor. There is a foyer before entering through a secure door into the dementia units. There are four stairway exits off the dementia unit that are key-padded.

The furnishings of the lounge have been obtained to include colour and interest. General household ornaments are used to creatively present the communal lounge areas as home like and interesting. Contrasting colours provide easier visibility and identification of furniture. Action boards are utilised for residents around the walls. There is a Closed Circuit Monitoring System with a 4 or 6 screen split that will be located on the nurse station desk. This system monitors the corridors of each wing and consequently staff are able to unobtrusively monitor residents who may be mobilising in corridors.

The external landscaping has been partially completed on the ground floor and safe areas available off level one for residents. The outdoor balcony area off the 3rd floor of the dementia unit is not yet fully completed.

E3.3e: The dementia unit is spacious. Resident rooms are all single and en-suited.

E3.4d: The open-plan living area is spacious and space and seating arrangements allow for both individual and group activities.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** PA Low

**Evidence:**

There is a Building WOF dated 1/7/14. A certificate of Public Use has been obtained for level one and two 6/8/14. Level three is yet to be signed off.

**Finding:**

Level three is in the process of being completed and therefore the certificate for public use has not yet been signed off.

**Corrective Action:**

A Certificate of Public Use (CPU) must be sighted by DHB/healthcert prior to opening

**Timeframe (days):** Prior to occupancy *(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:** PA Low

**Evidence:**

The external landscaping is has been partially completed and there are completed and safe areas off level one for residents.

There is an outdoor balcony off the dementia unit on the 3rd floor (7.7m x 5.2m). The trellis is a custom built heavy weight construction and is designed to resist horizontal forces that comply with the NZ Building Code. There is also a 600 mm overhang of the trellis so residents are unable to climb over this trellis. There are windows to be installed within the trellis that are reinforced safety glass. The balcony is in the process of being completed/landscaped.

**Finding:**

The balcony off the dementia unit is in the process of being completed/landscaped.

**Corrective Action:**

Ensure there is safe external areas for residents to access.

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

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities **(**HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

On level two and three, there are adequate numbers of toilets and showers with access to a hand basin and paper towels. All residents’ rooms have a private ensuite (toilet/shower/hand basin). There are also well placed communal toilet near the communal area.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Resident rooms on each floor are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. There is open-plan lounge/dining area on the second floor and a smaller sitting area. There is a spacious combined lounge/dining area on the third floor.

##### **Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

Level two (hospital) has a large lounge and connecting open-plan dining room. The communal living area is large enough for mobility equipment and lazy-boy chairs.

Level three (dementia) has a large lounge and connecting open-plan dining room.

E3.4b; The open-plan living area, hallways are spacious and allow maximum freedom of movement while promoting the safety of residents who are likely to wander.

##### **Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. The laundry is in the service area and has an entrance for dirty laundry and an exit for clean. The laundry is large and has commercial washing machines and dryers. The Ecolab manual includes instructions for cleaning. Linen is transported to the laundry in covered linen trolleys. There are employed laundry staff daily.

The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme.

The service has a secure area for the storage of cleaning and laundry chemicals. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are available and to be displayed in the cleaning cupboards, laundry and sluice (link 1.4.1). The laundry and cleaning areas have hand-washing facilities.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.7: Essential, Emergency, And Security Systems **(**HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

**Attainment and Risk:** FA

**Evidence:**

The Ryman group emergency and disaster manual includes (but not limited to) dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Emergencies, first aid and CPR is included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. Fire dills are completed six monthly at Beckenham. Fire drill was last completed 9/6/14 following opening of level one. The fire service completed fire training for the new building 6 June 2014. Further fire safety training is scheduled15/8/14. All registered nurses and senior caregivers have current first aid certificates. The fire evacuation plan has been approved by the fire service (dated 19/6/14.) Smoke alarms, sprinkler system and exit signs in place

The service has alternative cooking facilities (gas cooker) available in the event of a power failure. Battery operated emergency lighting is in place for two hours. There are also extra blankets available. There is a civil defence kit for the whole facility and stored water. There is a civil defence folder that includes procedures specific to the facility and organisation.

Call bells are evident in resident’s rooms, lounge area, and toilets/bathrooms. Senior caregivers will carry a pager and all calls are signalled on a screen with the room number at varied places throughout the facility.

The facility includes the Austco call bell system. When residents ring a light shines outside their room, on a control panel and also goes to staff pages. There is also a certain call sound. When a staff member is in a resident room a green light shines above the resident's door. This allows for staff to know where other staff are. If the staff member with a resident rings the bell for another staff member assist, this ring is different and allows for staff to alert other staff for assistance without leaving the resident unattended. In the dementia unit the system includes sensor bed mats that activate the lights in resident rooms, so when a resident gets up at night the light in their en-suite automatically turns on, this prompts the resident to go to the toilet and then on leaving the ensuite the light above the resident’s bed illuminates and encourages the resident to go back to bed.. This system is controlled by a timer and therefore can be set to meet the needs of individual needs of each resident. The door to each bedroom is also reed switched and should the resident open their door at night (or after their sensor system has been set) the alarm activates on the staff members pager. This way the staff member is alerted to which residents are up and wandering.

There is a Closed Circuit Monitoring System with a 4 or 6 screen split that will be located on the nurse station desk. This system monitors the corridors of each wing and consequently staff are able to unobtrusively monitor residents who may be mobilising in corridors.

##### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility. All rooms have external windows with plenty of natural sunlight.

##### **Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)**

Areas used by consumers and service providers are ventilated and heated appropriately.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(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:**

There are comprehensive infection control policies that meet the Infection Control Standard SNZ HB 8134.3.1.2008. There is policies including (but not limited to); a) a Scope and Application of the NZ standard for IC policy, b) infection control management policy, c) infection control governance policy, and d) defined and documented IC programme policy. There are clear lines of accountability to report to the IC team on any infection control issues including a reporting and notification to head office policy. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description.

The Defined and Documented IC programme policy states that the IC programme is set out annually from Head Office and is directed via the Ryman Accreditation Programmes annual calendar. The annual review policy states IC is an agenda item on the two monthly head office H&S committee.

The programme is reviewed annually through head office. The IC programme is fully established at Beckenham. The RN is the IC Coordinator. Infection control is included as part of the combined IC/H&S committee.

The service infection control manual includes a policy on a) Admission of Resident with Potential or Actual Infections policy, b) Infectious hazards to staff policy, c) Outbreak Management d) staff health policy and e) Isolation policy.

##### **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.)*

##### **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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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