# Ryman Healthcare Limited - Margaret Stoddart Retirement Village

## Current Status: 30 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

Ryman Margaret Stoddart is situated in Christchurch. The service has 41 bedrooms for residents requiring rest home level care. Occupancy during the audit was 37 residents. Additionally there are 25 serviced studios certified to provide rest home level care, occupancy on the day of the audit was eight rest home level residents.

There is an implemented quality process and training plan. Family feedback during the audit was very positive

Margaret Stoddart is managed by a registered nurse and clinical manager and supported by a stable staff. All residents interviewed spoke positively about the care and support provided by staff and management.

Neither the previous audit nor this audit has identified any shortfalls.

## Audit Summary as at 30 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 |
|  | 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 30 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 30 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 30 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 30 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 30 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 30 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:** | Ryman Healthcare Limited |
| **Certificate name:** | Ryman Healthcare Limited - Margaret Stoddart Retirement Village |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Margaret Stoddart Retirement Village | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 30 July 2014 | **End date:** | 30 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:** | 45 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 8 | **Hours off site** | 7 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 8 | **Total hours off site** | 5 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 1.5 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 13.5 | Total audit hours | 29.5 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 9 | Number of staff interviewed | 10 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 51 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, 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 Friday, 5 September 2014

## **Executive Summary of Audit**

**General Overview**

Ryman Margaret Stoddart is situated in Christchurch. The service has 41 bedrooms for residents requiring rest home level care. Occupancy during the audit was 37 residents. Additionally there are 25 serviced studios certified to provide rest home level care, occupancy on the day of the audit was eight rest home level residents.

There is an implemented quality process and training plan. Family feedback during the audit was very positive

Margaret Stoddart is managed by a registered nurse and clinical manager and supported by a stable staff.  
All residents interviewed spoke positively about the care and support provided by staff and management.

Neither the previous audit nor this audit has identified any shortfalls.

**Outcome 1.1: Consumer Rights**

Residents and staff report full information is provided at entry to residents and family/representatives. Regular contact is maintained with family including if an incident or care/medical issues arise as evidenced in incident reports and progress notes.

There is a complaints register that is up to date and includes relevant information regarding the complaint.

**Outcome 1.2: Organisational Management**

The service continues to implement the Ryman quality programme. A quality assistant checklist and Ryman Accreditation Programme (RAP) checklist is forwarded to head office each month to demonstrate implementation of the quality programme. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six-month period. Resident meetings are held on a two monthly basis. Relative meetings are held six monthly. Annual resident and relative surveys are completed. The internal auditing annual schedule is implemented as per schedule.   
Margaret Stoddart has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. There is a specific employees' induction manual. The in-service training programme identifies regular in-services, Margaret Stoddart have implemented a follow-up training requirement for staff who do not attend the in-service. The determining staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale and staff report management are responsive to any change in workloads.

**Outcome 1.3: Continuum of Service Delivery**

Service delivery plans demonstrate service integration. Assessments and support plans identify who is responsible for the actions. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly. Interventions including activities of daily living, management of weight loss and management of challenging behaviours are well documented and implemented. Activities provided for residents are varied, age appropriate and include inclusion at local community and entertainment events.

The medication management system is appropriate. Staff responsible for medication administration are trained and monitored. Medications are reviewed by the residents’ general practitioner at least three monthly. Individual resident’s medication charts were sighted.

The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission this is reviewed six monthly as part of the care plan review. Relative and resident meetings are held and meals are discussed. All residents interviewed stated that the food was excellent.

**Outcome 1.4: Safe and Appropriate Environment**

Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness which expires on 1 July 2015. Hot water is monitored and records show these are maintained within safe limits.  
The facility, inside and out, has been refurbished and all surfaces sighted were hazard free.

**Outcome 2: Restraint Minimisation and Safe Practice**

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

**Outcome 3: Infection Prevention and Control**

All infections are collected via the ‘infection report form’, collated in VCare system, and tabled at the quality meetings. The health and safety meeting acts as infection prevention and control committee meeting and the statistics are tabled. The meeting minutes reference other locations of information. The generated report is sent to head office for benchmarking against other Ryman facilities of the same level of care.

Surveillance methods and processes including individual infection reports adequately identify the needs of the residents. Internal audits are completed.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

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

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

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

## **Outcome 1.1: Consumer Rights**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

Residents and staff report full information is provided at entry to residents and family/representatives. There were no family members available to interview on the day of the audit. Regular contact is maintained with family including if an incident or care/medical issues arise as evidenced in incident reports and progress notes.   
ARC D11.3 The village manager reported the information pack is available in large print and advised that this can be read to residents.  
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

D16.1b.ii: The residents and family are informed in the entry pack prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  
D16.4b: No family were available for interview on the day of the audit. Documentation reviewed stated family members informed for incidents or health status changes.  
A sample of incidents forms (seven) reviewed identified that all evidenced that family were contacted or consent was not given to do so.   
Minutes of two monthly resident meetings and six monthly relative meetings were sighted and feedback was included in the autumn newsletter sighted. In the May 2014 relative survey, 100% used either good or very good to rate each section including communication.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system.   
A complaints register is maintained and shows investigation of complaints, dates and confirmation of resolution. Actions taken for resolution are referred to in the quality committee meeting minutes. Complaints are documented on VCare. This is also accessible by head office; complaints are given a risk rating.   
Complaints and verbal complaints reviewed for 2013 (three) and 2014 to date (one written) were tracked, indicating that they had been actioned according to timeframes and identified resolution. The monthly staff meeting identified discussion of complaints and opportunities for improvement in service delivery.  
Interviews with nine residents confirmed that they were well informed around the complaint process or would ask staff.  
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:**

Ryman Margaret Stoddart is situated in Christchurch. The service has 41 bedrooms for residents requiring rest home level care. Occupancy during the audit was 37 residents. Additionally there are 25 serviced studios certified to provide rest home level care, occupancy on the day of the audit was eight residents requiring rest home level care.   
   
Ryman has robust quality and risk management systems implemented across its facilities that are monitored by reports weekly reports to head office by the village manager and forwarding of the monthly RAP committee meeting minutes. There are clear guidelines and templates for reporting.   
The clinical auditor carries out spot audits to a comprehensive audit tool covering all aspects of the health and disability service standards and the ARC contract. The completed audit tool was sighted on line as completed for Margaret Stoddart in May 2014.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.

Margaret Stoddart objectives in 2014 include (but not limited to); a) any H&S issues dealt with in a timely manner; b) urinary tract infections (UTI) figures to be below MOH standard guidelines; c) staff team building; d) write and publish a book about the life of residents; e) management of alcohol using residents if an issue; f) use of V-care for clinical reports such as wounds. Reporting on progress to meeting objectives occurs quarterly and was sighted in meeting minutes.  
  
The service has in place a Village Manager, registered nurse (RN) who has been in the role for the last 2 years. She has attended the yearly Ryman conference for updates on rollout of specific Ryman objectives and leadership training. She is supported by an experienced clinical manager (RN) whom has been in the role for the last 10 years. The regional manager and clinical auditor provide further support on a regular basis.  
ARC, D17.3di (rest home), training records sighted evidenced the village manager and clinical manager have maintained at least eight hours annually of professional development activities related to management and both have met the training requirements to gain their nursing annual practicing certificates.   
  
Improvement Note:   
The service could consider having meeting minutes include enough information to give an overview of progress toward objectives.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** FA

**Evidence:**

Margaret Stoddart continues to implement a comprehensive quality and risk management system that is directed by head office. The RAP includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Margaret Stoddart at the onsite monthly RAP staff meetings and weekly management meetings.  
  
Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with six caregivers and review of the staff meeting minutes demonstrate their involvement in quality and risk activities. Caregivers gave a very positive account of the project to increase the caregiver knowledge of resident’s personal history through programmed time to talk with a resident they do not know well.   
  
Resident meetings are held on a two monthly basis. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. The relative survey May 2014 identified 100% of respondents used either very good or good as their response. The resident survey October 2013 resulted in a four point quality action plan (QIP) that was included in the RAP correction action plans and reported on. The resident autumn newsletter sighted included results of the survey.   
  
D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The quality and risk system is documented and links with associated policies/procedures. The RAP programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly RAP calendar (sited). There are adequate clinical policies and procedures to rest home level care. The two monthly journal club (attended by the three registered nurses) is directed by head office, reviews the latest clinical practice articles. The village manager’s journal was sighted.  
  
A quality assistant checklist and RAP checklist is forwarded to head office each month to demonstrate implementation of the quality programme. a) There is monthly accident/incident reports completed that break down the data collected across the facility. Reports are provided from the village manager to head office that includes a collation of staff incidents/accidents and resident incidents/accidents. Margaret Stoddart also provides a six monthly comparative summary report that includes recommendations for residents and staff and training conducted. These are also compared with the previous six month. b) The monthly manager's report includes complaints/concerns/compliments. Quality improvement plans are initiated where required (link 1.1.13.1). c) All infections are documented in a monthly summary report and discussed in the bi-monthly health and safety / IC meeting with a report forwarded to the monthly RAP committee meeting. Monthly reports to head office include a monthly summary of infections, statistics, clinical summaries and education. d) Health and safety is addressed through the two monthly health and safety meeting, e) the restraint approval group meets six monthly.   
Monthly benchmarking occurs throughout the Ryman group.

The service collects data to support the implementation of corrective action plans. QIPs sighted include: (i) chemical store left open when unattended and trolley in use not in the sight of a staff member; (ii) wound care charts signed off; (iii) immediate action when a hazard identified. All were checked on the day of the audit and were correct in line with the required action.   
The internal auditing annual schedule is implemented as per schedule. There has been a recent change in who completes each audit with the creation of a clinical auditor position. An organisational spot audit by the clinical auditor and a support auditor was completed in May 2014 which includes (but not limited to) review of clinical documentation and practise. The report was sighted on line. Other audits are completed between the village and clinical managers. Meetings are minuted with reference to location of details of actions required and resolved for areas identified for improvement and quality improvement plans/action plans are developed when quality activities such as internal audits and satisfaction surveys identify areas for improvement.  
  
D19.3 Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed and interview with six caregivers that included the representative on the committee were able to outline risk management and hazard control activities and requirements. Risk management, hazard control and emergency policies and procedures are in place. The organisation's benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.  
  
D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Manual handling training is provided to staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. A six monthly comparative analysis is completed of incidents for internal benchmarking. In addition, each facility receives an analysis of the last six monthly period from which to identify trends and improvements. These reports were sighted during the audit.   
   
Minutes of the monthly RAP committee meetings, two monthly health and safety meetings, which include infection control and monthly full facility meetings reflect a discussion of incidents/accidents. Monthly analysis of incidents includes comparison with previous month.

An incident reporting severity matrix has been developed by head office and is implemented at Margaret Stoddart.

Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Incidents details are entered into V-care as the investigations are completed and a report generated at the end of the month. Incident reports are then filed in the resident or staff members file. The monthly report for June was viewed that documented 24 reports. July reports to date were 19 and analysis was underway. Two reports in the complaints file and five in the resident file sample were reviewed, also seven falls reports for one resident. All forms were fully completed and included registered nurse assessment. The resident with frequent falls had assessment and short term care plan developed.

The service had engaged with the “65 Alive” project for a resident who used alcohol with resulting incidents. The resident has attained abstinence and no further incidents have been reported. The facility had a letter of thanks and congratulations on their efforts from the alcohol and other drug clinician.

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

D19.3c Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A register of registered nurse practising certificates is maintained within the facility and was sighted on the day of the audit as current.

There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed and also the information available for the village manager (the main file is held at head office). One file was for a long term staff member employed prior to some of the current requirements and therefore not evidenced. The remaining four had completed reference checks, police checks, induction and all had up to date appraisals.  
Margaret Stoddart has in place a comprehensive orientation/induction programme that provides new staff with relevant information for safe work practice. On interview with six caregivers this was confirmed as required and completed. It is tailored specifically to each position such as (but not limited to) caregiver, registered nurse, H&S rep. There is a specific employees' induction manual. Written questionnaires are completed for areas such as culture, complaints, advocacy and informed consent and were sighted on file for four staff. The orientation process includes; full induction with all employees and caregiver modules followed by enrolment into the ACE programme, four of the six caregivers interviewed have attained National certificate in aged care and report they were supported by Margaret Stoddart to do so.  
The 2013 – 2014 to date in-service training programme well exceeded eight hours annually. The village manager described a focus on ensuring staff that do not attend the in-service training read and understand the material presented and records of the last two in-service follow-up was sighted.

Registered nurses are supported to maintain their professional competency. Staff training records are maintained. The journal club for qualified nurses meets two monthly, the programme and journal for the village manager was sighted

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

**Attainment and Risk:** FA

**Evidence:**

There is a staffing levels and skills mix policy that documents rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents and rosters are in place. Staff reported that staffing levels were adequate and they were well supported by management.

The service provides a clinical manager (RN) Sunday to Thursday and an RN Friday and Saturday. This senior over sight supports caregivers across all shifts, including designated caregivers for the apartments.

There is 24 hour RN on-call cover and interviews with the six caregivers (across AM/PM shifts) confirmed that is never a problem ringing the manager or clinical manager at any time. There is a RN on duty seven days a week. Interviews with six caregivers confirmed that staffing levels were good and they were well supported by management. They stated the village manager was responsive to increased work levels when there were high dependency residents and was proactive in referring, where appropriate to NASC team for a reassessment of resident needs.

##### **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:**

Ryman Margaret Stoddard has comprehensive policies and procedures around care planning and times frames to guide staff. Timeframes are identified for assessment, initial care plan, long term care plan and evaluations. Six resident files reviewed complied with identified time frames.

D16.2, 3, 4; An initial assessment and initial care plan is completed within 24 hours. The remaining sections of the nursing care plan are completed within 21 days. This care plan is evaluated at six months and a V Care plan is created including evaluations and review of assessments. The care plan is developed and reviewed by the clinical manager (RN) or the service registered nurse. Resident files documented changes with resident health changes.

D16.5e; All six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident five files reviewed that the GP has assessed the resident as stable and is to be seen three monthly, one file was respite.

Staff emphasise that family are, where appropriate, involved from time of admission and continue to be involved when there is a review of the support plan. Communication with family is documented in the progress notes and a relative notification stamped on file. A letter is sent to relative prior to the GP reviews and care plan acknowledgment forms document family involvement in care planning.

Handover booklets document handovers between shifts and a handover between shifts was confirmed by five caregivers interviewed.

Progress notes are maintained. Advised that progress notes are only required to be written if there is anything relevant reported but at least once a week. Progress notes reviewed were written most shifts. A weekly management meeting provides an opportunity to discuss any clinical issues.

Tracer

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Six resident files were reviewed. The care plans for all residents were documented well. This includes alerts for early signs of chest infections and care of oxygen, interventions for challenging behaviour, dietitian referral in implementation of dietitian plans, management of diabetes and recognition of hypoglycaemia as examples.  
  
All seven residents and the GP interviewed reported that resident needs were being appropriately met.   
The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives.   
D18.3 and 4: Dressing supplies are available and a treatment room is stocked for use.  
Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  
Specialist continence advice is available as needed and this could be described.  
Continence management in-services and wound management in-service have been provided.  
Wound assessment and wound management plans/skin tear plans are in place for two wounds. There is one current pressure area and one knee graze. There is a wound and skin tear register. Evaluations, wound assessments and pain level is carried out at each dressing change. The clinical manager interviewed also has access to Ryman wound care nurse or external wound specialist as required.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is an activities coordinator for the rest home who is currently studying for the diversional therapist qualification. Another activities coordinator works with residents in the serviced apartments and town houses. The service continues to provide a high standard of activities for the residents in the rest home.

Activities are generally completed in either the main dining room or one of two large lounges and are provided over five days a week. There is an activities section in the resident file that include and activities assessment, 'your life experiences', next of kin input into care and an activities care plan. The care plan includes headings for comfort and wellbeing, outings, interests and family and community and entertainment. The care plan also includes 'Spice of Life' information - pertaining to what is important to the individual resident.

The service activities programme supports resident’s activity and is sufficiently comprehensive to meet the needs of residents. Nine residents stated the activities programme is enjoyable and interesting. Van outings are provided on a weekly basis. A 'Triple A' strength training programme is being implemented as part of falls prevention with exercise activities observed on day of audit.

D16.5d Resident files reviewed (six) identified that the individual activity plan is reviewed when at care plan review.

##### **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 V care evaluation template describes progress against every goal and need identified in the care plan (sighted). Short term care plans are well utilised. Any changes to the long term care plan are dated and signed. Six care plans reviewed included handwritten updates to the plan as needs have changed.   
Short term care plans were cited for wounds, weight loss, UTIs and poor appetite.  
D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.  
ARC: D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical services manual includes a comprehensive set of medication policies.

Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.  
Controlled drugs are stored in a locked cabinet inside the locked nurse’s office. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly by the staff and six monthly by the pharmacy. Medication fridges are monitored weekly.  
Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival.   
All senior caregivers administering medication complete a medication package. An annual medication administration competency is completed of each staff member and are updated annually.  
There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available and has been completed and reviewed six monthly for the two residents who self-administer (inhalers).

Twelve medication charts reviewed all were clear and easy to I understand, signing on administration was up to date including PRN medication. Resident photos and allergies are on all the drug charts. One medication chart included a controlled drug medication and this medication signing chart and the Controlled Drug book had two signatures documented for medications administered.  
D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

All kitchen staff have completed food safety training. The service has a large workable well equipped kitchen. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a winter and summer menu which follows a five week roll over pattern.   
All meals are cooked in the main kitchen and served from the kitchen directly to the residents in the dining room.   
Diets are modified as required. A summary sheet of resident special needs and dislikes is prepared by the village manager to enable quick reference for all food service staff. Caregivers were sighted on the day of the audit assisting with food service and contributing to ensuring the needs of the residents were met. There are currently four residents with a dietitian prepared nutritional plan in place and on interview the cook was able to speak as to ensuring these requirements were met.

Kitchen fridge, food and freezer temperatures are monitored and documented by the cook weekly which is more than the policy requires.

There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets which was sighted.   
All residents have a nutritional profile completed on admission and copied to the kitchen. This is reviewed six monthly as part of the care plan review. Changes to resident’s dietary needs are communicated to the kitchen by the registered nurses.

A food feedback book has been placed in the dining room for residents to enter comment at any time. This was reviewed and a number of suggestions had been made. There were no specific complaints documents. On discussion with the village manager she stated she spoke with any residents who added their name in the food feedback book to report an outcome to their suggestions. Interview with nine residents reported the food is very good and individual preferences are catered for.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

#### Standard 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

**Attainment and Risk:** FA

**Evidence:**

Building maintenance is carried out when necessary and records maintained. There is access to necessary and essential equipment. The building holds a current warrant of fitness, issued 1 July 2014. There are maintenance policies and procedures in place including electrical checks and a preventative maintenance schedule being implemented for 2014. Hot water is monitored and records show these are maintained within safe limits.  
The facility, inside and out, has been refurbished and all surfaces sighted were hazard free.

There has been an improvement objective to ensure all identified hazards are addressed in a timely manner, review of the maintenance book identified this was being met.

ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, heel protectors, and lifting aids.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

Consumers are provided with safe and accessible external areas that meet their needs.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint management policies and procedures are comprehensive; include definitions, processes and use of enablers.  
The restraint minimisation manual identifies that enablers are voluntary and the least restrictive option. There are no enablers or restraints currently in use at Margaret Stoddart. Challenging behaviour and restraint training has been provided to staff.

A reported incident of resident aggression to another resident was investigated. The investigation found staff implemented appropriate de-escalation strategies. Follow-up and outcome reviewed indicated the incident was well managed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

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

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

**Attainment and Risk:** FA

**Evidence:**

Infections are collected via the ' infection report form' and all collected and discussed at the RAP meetings. Following this, the report information is entered onto the VCare system and a collated report of generated. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the consumers.   
The infection control (IC) Officer (clinical manager) then reports infection stats to the bimonthly H&S/IC meeting and a six monthly comparative summary is completed and forwarded to head office. All meetings held include discussion on infection control. The objective is for infection rate to be below the “indicators for safe aged care” guidelines. Internal audits are completed. Infections are benchmarked across the organisation.

Improvement Note:

Clearly define infection control discussion in the H&S meeting minutes.

##### **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.)*