

# Anthony Wilding Retirement Village Limited

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Current Status: 6 October 2014

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

Anthony Wilding provides care across three levels. On the day of audit, there are 34 (of 35) residents in the rest home, 76 hospital and two rest home (of 80) residents in the hospital wings and 31 (of 33) dementia level residents in the special care unit which is on level two. There are 20 serviced apartments that have previously been certified as suitable for rest home level care and on the day of audit there are eight rest home level residents in apartments. This audit also included verifying a further 10 serviced apartments as suitable to provide rest home level care.

The village manager at Anthony Wilding is non clinical and has been in post for six months. She is supported by a relieving assistant manager who carries out administrative functions; and a clinical manager (RN) who oversees clinical care at the care centre. The clinical manager has been in post five months. The management team is supported by the Ryman management team including the regional manager.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are improvements required around care planning documentation, progress notes, medication management and aspects of wound documentation.

## Audit Summary as at 6 October 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

Indicator	Description	Definition
	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 6 October 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 6 October 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 6 October 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 6 October 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 6 October 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 6 October 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.
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## Audit Results as at 6 October 2014

### Consumer Rights

Anthony Wilding endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are being implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are being implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaint processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### Organisational Management

Anthony Wilding is implementing the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Anthony Wilding provides clinical indicator data for the three services being provided (hospital, rest home and dementia). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

### Continuum of Service Delivery

There is comprehensive information available. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whānau interviewed confirmed they are involved in the care plan process and

review. Short term care plans are in use for changes in health status. There is an improvement required around progress notes, documentation of interventions and aspects of wound documentation.

The activity officers designated to provide an activities programme in each unit ensure the abilities and recreational needs of the residents is varied, interesting and involves the families and community. There are 24 hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. There is an improvement required around aspects of medication management and documentation.

Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

### **Safe and Appropriate Environment**

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensembles. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

### **Restraint Minimisation and Safe Practice**

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and on-going. The service currently has 12 hospital residents who have been assessed as requiring restraint. There is one hospital resident with an enabler (bedrails).

### **Infection Prevention and Control**

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service

engages in benchmarking with other Ryman facilities. Staff receive on-going training in infection control.

# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	Anthony Wilding Retirement Village Limited		
<b>Certificate name:</b>	Anthony Wilding Retirement Village Limited		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Certification Audit		
<b>Premises audited:</b>	Anthony Wilding Retirement Village		
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 6 October 2014	<b>End date:</b> 7 October 2014	
<b>Proposed changes to current services (if any):</b>	Ten serviced apartments were assessed as suitable to provide rest home level care. This increases certified serviced apartments to 30.		
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			151

## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	16	<b>Hours off site</b>	5
<b>Other Auditors</b>	XXXXXXXX	<b>Total hours on site</b>	32	<b>Total hours off site</b>	10
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	48	Total audit hours off site	17	Total audit hours	65
Number of residents interviewed	11	Number of staff interviewed	25	Number of managers interviewed	2
Number of residents' records reviewed	13	Number of staff records reviewed	18	Total number of managers (headcount)	2
Number of medication records reviewed	26	Total number of staff (headcount)	212	Number of relatives interviewed	8
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

I, XXXXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	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 Monday, 10 November 2014

## Executive Summary of Audit

### **General Overview**

Anthony Wilding provides care across three levels. On the day of audit, there is 34 (of 35) residents in the rest home, 76 hospital and two rest home (of 80) in the hospital wings and 31 (of 33) dementia level residents in the special care unit which is on level two. There are 20 serviced apartments that have previously been certified as suitable for rest home level care and on the day of audit there is eight rest home level residents in apartments. This audit also included verifying a further 10 serviced apartments as suitable to provide rest home level care.

The village manager at Anthony Wilding is non-clinical and has been in post for six months. She is supported by a relieving assistant manager who carries out administrative functions and a clinical manager (RN) who oversees clinical care at the care centre. The clinical manager has been in post five months. The management team is supported by the Ryman management team including regional manager

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There are improvements required around care planning documentation, progress notes, medication management and aspects of wound documentation.

### **Outcome 1.1: Consumer Rights**

Anthony Wilding endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are being implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Policies are being implemented to support residents' rights. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaint processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

### **Outcome 1.2: Organisational Management**

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

practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes

### **Outcome 1.3: Continuum of Service Delivery**

There is comprehensive information available. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whanau interviewed confirmed they are involved in the care plan process and review. Short term care plans are in use for changes in health status. There is an improvement required around progress notes, documentation of interventions and aspects of wound documentation.

The activity officers designated to provide an activities programme in each unit ensure the abilities and recreational needs of the residents is varied, interesting and involves the families and community. There are 24 hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. There is an improvement required around aspects of medication management and documentation.

Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

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

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensuite. There is sufficient space to allow the movement of residents around the facility using the mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on site at all times. Housekeeping staff maintain a clean and tidy environment.

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

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and on-going. The service currently has 12 hospital residents who have been assessed as requiring restraint. There is one hospital resident with an enabler (bedrails).

### Outcome 3: Infection Prevention and Control

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

### Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	47	0	1	2	0	0
Criteria	0	97	0	2	2	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	0
Criteria	0	0	0	0	0	0	0	0

### Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	One resident in the dementia unit has a wound that was assessed by the GP. Nursing staff documented the next day that the resident had pain in relation to the wound. There have been no further entries in the progress	Ensure progress notes record significant events, interventions and outcomes to promote continuity of service.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				notes for seven days. (Noting, wound assessments completed contain an assessment of pain at each dressing change).		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)The wound log in the hospital does not reflect the number of actual wounds. The wound documentation could not be found for one hospital resident with a pressure area. Evaluations and change of dressings have not been carried out as per the documented frequency for four pressure areas (hospital). Evaluations have not been carried out for five skin tears (three hospital and two dementia care) as per the required frequency on the skin tear short term care plan. (ii) Care plans do not document the following interventions; a) one dementia care resident with on-going skin tears, b) No behavioural assessment or nursing care plan for one hospital resident exhibiting aggressive and resistive behaviour as per progress notes, c) changes in dietary requirements for rest home resident with weight loss. The same resident has not had a pain assessment for shoulder pain on admission and for exacerbation of shoulder pain post fall. (iii) Two residents with chairbrief restraints did not have interventions	(i) Ensure wound evaluations are completed at the required frequency, (ii) Ensure interventions are documented to reflect the resident's current needs.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				documented to manage the risks identified, (iv) two residents with restraint removed through the assessment/evaluation process had contradictory interventions within the care plan.		
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 Moderate			
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 Moderate	1) The standing orders have not been signed by the GPs. (Advised that standing orders are reviewed annually and sent out in July RAP programme); 2) One XXXX injection in the hospital medication fridge expired December 2013. 3) Twice daily eye drops for rest home resident in serviced apartments have not been documented as administered. 4) Discontinued medications on seven (2 hospital, two rest home and three dementia) medication charts have not been signed by the GP. There are no indications for use of PRN medications on three (one hospital and two dementia) out of 26 medication charts (XXXXXXXXXX).	1) Ensure standing orders are valid. 2) Ensure emergency medications are within expiry dates. 3) Administer medications as prescribed. 4) Ensure discontinued medications are signed by the GP, Ensure PRN medications have an indication for use.	60
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There are two residents in the serviced apartments who self-medicate a) eye drops and b) laxatives. Competency assessments for self-medication have not been completed. There is no monitoring of the self-medicating residents.	Ensure self-medicating residents are competency assessed and monitored as per protocol.	60

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## 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 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)**

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

**Attainment and Risk:** FA

**Evidence:**

Ryman policies and procedures are being implemented and align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission which includes the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interview with nine caregivers (two dementia, two rest home, four hospital and one that works across all areas) demonstrate an understanding of the Code. Resident rights/advocacy training was provided in April 2014 (62 attended). Residents interviewed (five rest home, including two in serviced apartments and six hospital) and relatives (five hospital and three dementia care) confirm staff respect privacy, and support residents in making choice where able

### **Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)**

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

**Attainment and Risk:** FA

**Evidence:**

There is a welcome pack that includes information about the Code and the opportunity to discuss prior to, and during the admission process with the resident and family is provided. Information is also given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Large print posters of the Code and advocacy information are displayed through the facility. The bimonthly resident meetings also provide the opportunity for residents and relatives to raise issues/concerns (minutes sighted). Residents and relatives interviewed confirmed that information has been provided around the Code. The village manager has an open door policy for concerns or complaints.

D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, CoR pamphlet, advocacy and Health & Disability Commission. The village manager and clinical manager described discussing the information pack with residents/relatives on admission.

D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

### Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

**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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)**

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention 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 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)**

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

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

**Attainment and Risk:** FA

**Evidence:**

Ryman has policies that support resident confidentiality, privacy, collection and storage of information, and access to health information (disclosure). A tour of Anthony Wilding confirms there is the ability to support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Resident files are stored out of sight. Staff could describe definitions around abuse and neglect that align with the Ryman policy. All relatives interviewed stated that the care provided is overall good. Prevention and detection of abuse training was last delivered in June 2014 (32 attended). There is no evidence of abuse/neglect. An annual resident satisfaction survey has been completed.

D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Interview with nine caregivers describe how choice is incorporated into resident cares. Interview with 11 residents (three rest home, two rest home in serviced apartments and six hospital) inform staff are respectful. There is an abuse and neglect policy that is being implemented and staff attend in-service education on abuse and neglect. Interviews with residents and family members were generally positive about the care provided.

E4.1a: Three relatives (with a family member in the unit) interviewed stated their family member was welcomed into the dementia unit and personal items were evident in rooms to make it more familiar to the resident.

D4.1a: 13 resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes cultural, religious, social and ethnic needs. Interviews with ten residents confirm their values and beliefs were considered.

D14.4: There are instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)**

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

**Attainment and Risk:** FA

**Evidence:**

A3.2 Ryman has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff report there is one resident that identifies as Maori who has a fully completed Maori health plan, the resident has identified cultural/spiritual needs after death which is detailed in the plan.

Maori Beliefs training has been provided to staff January 2014 and care for a Maori resident dying February 2014.

D20.1i The Ryman Maori health policy guides staff in cultural safety. Special events and occasions are celebrated and this could be described by staff

**Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)**

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

**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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)**

The organisation plans to ensure Māori receive services commensurate with 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.)*

**Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)**

The importance of whānau and their involvement with Māori consumers is recognised and supported 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 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)**

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

**Attainment and Risk:** FA

**Evidence:**

An initial care planning meeting is carried out, where the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives inform values and beliefs are considered. Discussion with 11 residents (five rest home residents including residents in serviced apartments and six hospital) confirm that staff take into account their culture and values.

D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.

D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs

### **Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)**

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

**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 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

**Attainment and Risk:** FA

**Evidence:**

Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Ryman Accreditation Programme (RAP) full facility (include all staff) meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager and registered nurses confirm an awareness of professional boundaries. Interview with nine caregivers (two dementia, two rest home and four hospital and one who works across all areas) could discuss professional boundaries.

### Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being 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.)*

### Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

**Attainment and Risk:** FA

**Evidence:**

Ryman Healthcare has a Ryman Accreditation Programme (RAP) that includes an annual planning and a suite of policies/procedures to provide rest home care, hospital care and specialist dementia care. Policies are reviewed at an organisational level and input is invited from facility staff (verified via interview with managers and registered nurses). All Ryman facilities have a master copy of all policies and procedures and a master copy of clinical forms available on the Ryman intranet. These documents have

been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies.

Clinical indicator data is collected against each service level and reported through to head office for monitoring. Indicators include (but not limited to): falls, medication errors, infection. Feedback is provided to staff via the various meetings that are determined as part of the RAP. Quality Improvement Plans (QIP) are developed where thresholds exceed expectation e.g.: QIP for falls was sighted. QIP's are also developed opportunistically, and all reviewed are seen to be resolved and closed out. Vcare is the electronic system used by all sites to report relevant information through to head office, and is seen to be used at Anthony Wilding.

ARC A2.2 Services are provided at Anthony Wilding that adhere to the health & disability services standards. There is a quality improvement programme that is being implemented that includes performance monitoring. ARC D1.3 all approved service standards are adhered to.

There are human resources policies/procedures to guide practice, and an annual in-service education programme that is incorporated into the RAP. There is evidence at Anthony Wilding that the in-service programme is being implemented. There is evidence of opportunistic education being provided at handovers.

There is a journal club being implemented at Anthony Wilding that has been established by head office. The intent of the journal club is to foster on-going professional development for the registered and enrolled nurse workforce. The articles /research are provided by head office including a suite of related questions that are discussed as part of the journal club process. There is a 2014 training plan developed for Anthony Wilding that is aligned with the RAP. Anthony Wilding have dedicated staff supporting implementation of the training programme including participation in the ACE programme for caregivers. Ryman has a 'Duty Leadership' training initiative that all registered nurses (RN)s, enrolled nurses (EN)s and Senior Leaders complete. It includes four modules/assignments around resident rights, customer service, leading colleagues and key operations/situation.

ARC D17.7c There are implemented competencies for caregivers and registered nurses. Core competency assessments and induction programmes are being implemented at Anthony Wilding. Competencies are completed for key nursing skills including (but not limited to); a) moving & handling, b) insulin, c) sub cut fluids and d) medication. RNs have access to external training.

Residents interviewed (six rest home – including two from the serviced apartments and five hospital) and relatives (five hospital, three dementia care) were positive about the care they receive.

### **Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)**

The service provides an environment that encourages good practice, which should include evidence-based practice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### 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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

There is an incident reporting policy, and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Incident forms reviewed identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters is available.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Eight relatives (five hospital, three dementia) stated that they are informed when their family members health status changes.

D11.3 The information pack is available in large print and this can be read to residents.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

**Attainment and Risk:** FA

**Evidence:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Consent is obtained for release of health information, photograph for identification and promotional displays, care choice/procedures and release of information to family or representative. Nine caregivers interviewed (who work morning and afternoons across the three levels of care) are familiar with the code of rights and informed consent when delivering resident cares. Written specific consents are sighted in resident files for student involvement in care and education, care and management of an indwelling catheter and percutaneous drain.

Resuscitation orders for competent residents are appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Advance directives are reviewed by the GP and residents are informed of their choice to withdraw or change their advance directive status. The GP discusses resuscitation with families/EPOA where the resident is deemed incompetent to make a decision. The resuscitation order is appropriately signed in 13 of 13 resident files sampled (six hospital, three rest home and four dementia care)

D3.1.d: Discussion with eight family members (five hospital and three dementia care) identifies that the service actively involves them in decisions that affect their relative's lives. Advanced directives are completed for residents who are competent to make the decision.

D13.1: Thirteen admission agreements are sighted and signed.

### **Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)**

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

**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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

**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 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

**Attainment and Risk:** FA

**Evidence:**

Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the village manager, the assistant village manager and the clinical manager confirm practice is consistent with policy. Interviews with 11 residents (six hospital, five rest home) confirm that they are aware of their right to access advocacy.

D4.1d; Discussions with eight family members confirm that the service provides opportunities for the family/EPOA to be involved in decisions  
ARC D4.1e. The resident files include information on residents' family/whānau and chosen social networks.

#### Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

**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 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

**Attainment and Risk:** FA

**Evidence:**

D3.1h: Interview with 11 residents and eight relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit.

The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with 11

residents confirm the activity staff help them access the community such as going shopping, going on site seeing tours, and going to church.  
D3.1.e Discussion with nine caregivers, five activities coordinators, eight relatives and 11 residents confirm that residents are supported and encouraged to remain involved in the community and external groups.

**Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)**

Consumers have access to visitors of their choice.

**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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)**

Consumers are supported to access services within the community when 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 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints policy and supporting documents that is being implemented. The village manager is overall responsible for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A feedback form is completed for each complaint recorded on the complaint register. The number of complaints received each month is reported monthly to staff via the various meetings – e.g. RAP management, full facility, RN. There is a complaints register maintained that includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with 11 residents and eight relatives confirm they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. There are 12 recorded complaints during 2014 year to date. The complaints reviewed had all been investigated with updates and resolution provided to complainants. All complaints were closed at the time of audit. QIPs sited in regards to one complaint regarding food, one complaint regarding call bells and two in relation to care. Education sessions sited as part of the QIPs established. 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:

Anthony Wilding provides care across three levels. On the day of audit, there is 34 (of 35) residents in the rest home, 76 hospital and two rest home (of 80) in the hospital wings and 31 (of 33) dementia level residents in the special care unit which is on level two. There are 20 serviced apartments that have previously been certified as suitable for rest home level care and on the day of audit there is eight rest home level residents in apartments. Under the medical component of their certification they have one YPD in the hospital and two residents under respite care. This audit also included verifying a further 10 serviced apartments as suitable to provide rest home level care.

There is a documented ' purpose, values, scope, direction & goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the RAP that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities. Ryman Healthcare have operations team objectives 2014 that include a number of interventions/actions for; a) quality system focus forward, b) national dementia project, c) human resources - recruitment/induction processes, d) health and safety, e) InterRAI project, and f) clinical education. Each service also has their own specific RAP objectives.

2014 objectives for Anthony Wilding are grouped under the following headings: resident/relative satisfaction, clinical, human resources and health and safety. Each main objective identifies the goal, desired outcome and implementation strategy. Progress towards the objectives is updated as part of the RAP schedule, with the last minuted update being August (2014).

The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and specialist dementia care. There is a medical component to the certificate. There is a contracted physiotherapist that provides services two days (8 hours) a week and a physiotherapist assistant that works 25 hours per week. There is a contracted medical centre that provides medical services.

The village manager at Anthony Wilding is non-clinical and has been in post for six months. She has a management background in occupational health. The village manager has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. She is supported by a relieving assistant manager who carries out administrative functions and a clinical manager (RN) who oversees clinical care at the care centre. The clinical manager has been in post five months. The management team is supported by the Ryman management team including regional manager.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Standard 1.2.2: 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:**

Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. During a temporary absence, the assistant manager and clinical manager will cover the manager's role. The assistant manager covers administrative functions and clinical manager clinical care. The regional manager provides oversight and support. D19.1a; a review of the documentation, policies and procedures and from discussion with staff, identified the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

### 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 1.2.3: 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:**

Anthony Wilding is implementing the Ryman RAP system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP Committee, full facility, registered/enrolled nurse, caregivers, restraint and H&S/IC. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.

The service has policies and procedures and the RAP programme defines systems to provide an assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies & procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow implementation by staff. A number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence/knowledge and education packages which are based on their policies.

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

Key components of the quality management system link to the RAP committee at Anthony Wilding who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports to that are sent to head office (Christchurch) provide a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical manager collected across the rest home, dementia unit and hospital services as well as staff incidents/accidents. The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. The Anthony Wilding combined health and safety/infection control committee meet bimonthly and include discussion of incidents/accidents and infection. Infection control is also included as part of benchmarking across the organisation (link 3.5).

Anthony Wilding is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. Repeat audit is required if results exceed the Ryman threshold (92%). Issues and outcomes are reported to the appropriate committee e.g. RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – e.g. Pressure areas and falls. Weekly reporting to the regional manager includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix. QIP's reviewed are seen to have been closed out once resolved. The QIP process is seen to have been well embedded into day-to-day operations at Anthony Wilding and include clinically focused improvements. The QI register identifies monitoring of quality improvements.

A resident survey was last completed May 2014, with an overall satisfaction rating of 95% for rest home residents and 90% hospital residents. A relative survey was completed February 2014. QIPs were developed in relation to meals, laundry and activities.

D19.3: There is a comprehensive H&S and risk management programme in place. There are policies to guide practice. Anthony Wilding has a H&S representative who has completed training.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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.

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

**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.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D19.3c: The service collects incident and accident data. Twenty-two randomly selected incident forms were reviewed and all had been completed appropriately including investigation and preventative actions. All had been reviewed and followed up by the clinical manager. Eight files were traced (three hospital, five dementia) and all reported incidents had an accompanying incident form.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark for example falls. Corrective action plans were completed and signed off.

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:**

The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Relevant documentation is seen in 18 staff files reviewed (two activity coordinators, clinical manager, two unit coordinators, five RNs, six caregivers, maintenance, and cook).

Additional role descriptions are in place for infection control coordinator, restraint coordinator, in-service educator, health and safety officer, fire officer. Policy: Health practitioners and competencies outlines the requirements for validating professional competencies. A register of practising certificates is maintained. Policy 2.7.1 Staff Administration identifies manager availability including on call requirements.

There are 84 caregivers working at Anthony Wilding. New caregivers complete full induction with all employees within first week then move to complete orientation and Ryman Caregiver induction modules. If not achieved prior to employment, caregivers are supported to enrol in on-going education to achieve National Certificate qualifications. This is coordinated by an onsite ACE/Induction/in-service Assessor. Recently caregivers employed gain Foundations Level 2 on completion of the caregiver induction. Caregivers complete yearly comprehension surveys. Role specific caregiver meetings held quarterly with additional meetings held as required. All meetings follow the terms of reference as outlined in policy and procedure manuals. Significant role in primary care nursing teams to provide tailored care to care centre residents through open dialogue with registered or senior staff of resident needs. Qualifications: nine- level II Foundations; seven - ACE Core; 44 - ACE Dementia; 24- ACE Advanced; seven- NZQA Level 3 NCCSS-Core Competencies; 18- NZQA Level 3 NCCSS-Residential; four- Foreign Trained Nurses and two ENs.

There is a 2014 training plan developed for Anthony Wilding that is aligned with the RAP. There is a registered nurse who oversees staff induction and the ACE programme, and one who facilitates the in-service calendar. The training programme exceeds eight hours annually and staff attendance has improved since previous surveillance audit.

Participation in the ACE programme is a requirement for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly at all Ryman facilities and recent subjects covered at Anthony Wilding include (but not limited to) pressure areas. 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.

The clinical structure in the facility includes a clinical manager, registered nurse coordinators in the hospital, rest home and dementia units and a team of registered nurses and care staff. The serviced apartments (where there is currently eight rest home level residents) have a coordinator (enrolled nurse). The clinical manager oversees the care planning/delivery process for rest home level residents in the apartments. In the absence of the clinical manager it is the Hospital coordinator responsibility.

E4.5f: There are currently 10 of 14 caregivers employed to work in the dementia unit that have completed the required dementia standards and four are in the process of completing.

Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Interviews with eight caregivers inform the RN's (including coordinators) are supportive and approachable. Interview with nine caregivers (four from PM shift and five from AM shift across the facility), three registered nurses, two enrolled nurses and three unit coordinators inform there are sufficient staff on duty at all times, however there has been an increase in new staff. Interviews with residents (11) and relatives (eight) inform there are times when the facility appears to be short-staffed, this was not observed during the audit. Staff and management inform there is capacity to increase staff numbers based on resident acuity, and there is access to both casual staff and part-time staff to cover unexpected absence.

All care centre rooms have been previously been assessed as 'dual purpose', and 20 serviced apartments assessed as suitable for rest home level care. This audit also included verifying a further 10 serviced apartments as suitable to provide rest home level care. There is a draft roster available for the increase in rest home residents. The serviced apartments are currently managed by an enrolled nurse with oversight from the clinical manager based in the hospital.

There is good registered nurse cover across the facility. Across the hospital units there are four rostered RNs in the morning shift, plus the clinical manager Mon - Fri, and four RNs afternoon shift. There is also an EN serviced apartment coordinator, a registered nurse across seven days in the rest home (morning shift) and across seven days in the dementia unit (morning shift and afternoon shift). At night, there are two RNs across the two hospital units, plus four caregivers and four caregivers across the rest home and dementia units. The clinical manager and hospital coordinators (RN) provide support to the rest home residents in the serviced apartment including maintaining and updating care plans. Physiotherapy assistant 0900-1300 Mon-Fri.

### 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.)*

## Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

**Attainment and Risk:** FA

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard in all areas. Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.

D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.

### Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and 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.)*

### Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

**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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**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 1.2.9.10 (HDS(C)S.2008:1.2.9.10)**

All records pertaining to individual consumer service delivery are integrated.

**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 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

**Attainment and Risk:** FA

**Evidence:**

The service has a well-developed assessment process and resident's needs are assessed prior to entry. The service has a comprehensive admission policies including: a) Entry of Resident to Services policy. The information booklet answers a number of questions around admission and entry processes. The clinical manager screens potential clients for entry to services and requests confirmation of the level of care prior to admission. Consultation occurs with clinical personnel regarding placement and specific clinical needs. There is currently a waiting list for rest home and special care (dementia) beds.

Three rest home and six hospital residents and eight relatives interviewed (five hospital and three dementia care) confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. Thirteen admission agreements sighted had been signed.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E3.1 Four resident files reviewed in the dementia unit included a needs assessment as requiring specialist dementia care.

### Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

**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 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)**

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

**Attainment and Risk:** FA

**Evidence:**

The right to appeal against assessment outcome policy states the manager at every stage will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry is referred back to the Needs Assessors or referring agency for appropriate placement and advice.

### **Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)**

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative 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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

**Attainment and Risk:** PA Low

**Evidence:**

The nursing care assessment, service delivery policy, care planning and interventions policy describes the responsibility around documentation. There is a continuum of service delivery policy that includes guidelines for a) nursing care assessment, b) planning care interventions, c) service delivery/interventions, and d) evaluation and care plan review. Timeframes are identified for assessment, initial care plan, long term care plan and evaluations. The registered nurses are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs. of admission. The initial assessment and support plan is reviewed and the long term care plan completed within three weeks of admission. Three registered nurses (RNs) and two unit co-ordinators (interviewed) know the timeframes for the development and reviews of care plans and files.

D16.2,3,4; All 13 resident files sampled (six hospital, four dementia care and three rest home) had initial assessments and initial care plans developed within the required timeframes. The long term care plans are in place and have been evaluated six monthly for five hospital residents, two dementia care and three rest home residents. One hospital and two dementia care residents have not been at the service long enough for a review.

Clinical staff have attended in service and refreshers on clinical care including (but not limited to) behaviour management, pain management, personal hygiene and grooming, palliative care, care planning and ageing process. A "Life experiences" and an activities assessment is completed on admission by the activity co-ordinators.

Nine caregivers interviewed (five morning shift and four afternoon shift who work across the three levels of care) could describe a verbal handover at the beginning of each shift that maintains a continuity of service delivery. There is a duty handover form which is completed for each shift in each level of care that lists any residents requiring any special observations or needs. Progress notes are written on every shift for hospital residents and at least weekly for rest home residents and at any other time for significant events. There is an improvement required to the frequency of progress notes in the dementia care unit.

A physiotherapist is contracted to the service for 12 hours a week to undertake new resident physiotherapy assessments, follow up any referrals, oversee the trial of equipment and forwards instructions to the physiotherapy assistant to continue treatments as required. The physiotherapist is based predominantly in the hospital unit and assesses residents in the rest home and dementia care by RN or GP referral. A referral was sighted for a hospital resident who has returned from hospital following a fall. The physiotherapist is observed communicating outcomes of assessments to the RN on duty and documenting physiotherapy reports in the resident file. Education in safe manual handling is provided as per the training schedule. The service employs a physiotherapy assistant for 30 hours a week to work alongside the physiotherapist and ensures exercises, assisted walking and assessments are followed up as per the physio therapist's instructions.

D16.5e; Medical assessments are documented in all 13 files within 48 hours of admission. The GP assessment form on admission states the frequency of routine visits from one to three months. Residents with unstable conditions are seen more frequently or as required. Three monthly medical reviews are documented in all 13 files by the general practitioner. More frequent medical assessment/ review noted occurring in residents with acute conditions (for example unstable diabetes) and those requiring palliative care. Medical care is contracted and provided by six GPs from a local health centre. Their clinic days three days each week. The GPs are on a roster to provide cover afterhours. Communication is by fax or phone for more urgent requests. The GP (interviewed) states requests for visits are appropriate and says her patients within all the units are well cared. Specialists including the geriatrician and consultant psychiatrist is readily available to the GP as required.

The clinical manager (interviewed) states the service has access to a dietitian, palliative care nursing team and community psychiatric nurses visit monthly and as required for the dementia care residents and other residents of concern.

Tracer methodology hospital resident:

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

Tracer methodology rest home resident:

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

Tracer methodology dementia care 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:** PA Low

**Evidence:**

Nine caregivers interviewed (five morning shift and four afternoon shift who work across the three levels of care) could describe a verbal handover at the beginning of each shift that maintains a continuity of service delivery. There is a duty handover form which is completed for each shifts that lists any residents requiring any special observations or needs. Progress notes are written on every shift for hospital residents and at least weekly for rest home and dementia care residents and at any other time for significant events.

**Finding:**

One resident in the dementia unit has a wound that was assessed by the GP. Nursing staff documented the next day that the resident had pain in relation to the wound. There have been no further entries in the progress notes for seven days. (Noting, wound assessments completed contain an assessment of pain at each dressing change).

**Corrective Action:**

Ensure progress notes record significant events, interventions and outcomes to promote continuity of service.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

#### **Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

**Attainment and Risk:** FA

**Evidence:**

The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food & nutrition information and mental function.

Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents including (but not limited to); a) waterlow pressure area risk assessment, b) skin integrity, c) three day continence assessment, d) coombes falls risk, e) dietary profile/nutritional needs screening f) pain/Abbey scale assessment g) physiotherapy assessment. h) Behavioural assessment i) wound assessment and enabler/restraint assessment (as applicable). Assessments are reviewed six monthly or when there is a change to condition.

E4.2; Four dementia resident files sampled included an individual assessment that included identifying diversional, motivation and recreational requirements.

E4,2a In four of four resident files sampled challenging behaviours assessments are completed. Behaviour nursing care plans are in place.

### Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An initial support plan is completed within 24 hours. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality. RNs are in the process of completing InterRAI training. Interview with five registered nurses (including two unit co-ordinators) and the clinical manager verified involvement of residents/families in the care planning process. Resident/family/whanau involvement is evidenced by signing the written acknowledgment of care plan form in six of six hospital resident files and three of three resident files sampled.

Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as physiotherapist, podiatrist, dietitian, palliative care nurse, community mental health nurse, needs assessors and consultant psychiatrist.

E4.3 Four of four resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status. Examples sighted are as follows: post fall with injury, weight loss, skin tear, pain, behaviours, falls, change in mobility, and chest infection.

D16.3f; Resident files sampled identified that the resident/family are involved in the development/evaluation of care plans.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents interviewed (six hospital, three rest home) report their needs are being appropriately met. Relatives interviewed (five hospital, three dementia care) state their relatives needs are being appropriately met and they are kept informed of any changes to health and interventions required. This is evidenced in the progress notes. When a

resident's condition alters, the registered nurse initiates a review and if required a GP visit. Faxes to the GPs for residents change in health status are sighted in the residents file.

D18.3 and 4 Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment and wound treatment and evaluation plans are in place in the hospital for nine skin tears, five minor wounds, two leg ulcers and 10 pressure areas; one heel (grade 2), one pressure area buttock (grade 3), five sacral pressure areas (two grade 1 and three grade 2), one pressure area of back (grade 1) and two ankle pressure areas (grade 1 and 2). There is an improvement required around the currency of the wound log and frequency of evaluations. There are wound mappings and size of wounds documented to monitor healing. There are two wounds in the rest home – XXXXXX There are two residents with skin tears in the dementia care unit. Short term care plans are in place for skin tears. The service has a "wound champion" who is involved in all complicated/non-healing wounds. There is also has access to external to wound specialist as required.

Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the three RN's and two unit co-ordinators interviewed. There are risk assessment tools available that are completed on admission, reviewed six monthly and when there are changes to health status as applicable. Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels, neurological observations and behaviour charts. There is an improvement required around the documentation of interventions to reflect the resident's current health status and restraint use.

Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour nursing care plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best used to manage behaviours. There is an improvement required around behaviour management for one hospital resident with challenging behaviours.

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

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

**Attainment and Risk:** PA Moderate

#### **Evidence:**

Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment and wound treatment and evaluation plans are in place in the hospital. There are wound mappings and size of wounds documented to monitor healing. There are two wounds in the rest home – one resident with an open wound on finger and one resident with a leg ulcer. There are two residents with skin tears in the dementia care unit. Short term care plans are in place for skin tears. The service has a "wound champion" who is involved in all complicated/non-healing wounds. There is also has access to external to wound specialist as required.

#### **Finding:**

(i)The wound log in the hospital does not reflect the number of actual wounds. The wound documentation could not be found for one hospital resident with a pressure area. Evaluations and change of dressings have not been carried out as per the documented frequency for four pressure areas (hospital). Evaluations have not been carried out for five skin tears (three hospital and two dementia care) as per the required frequency on the skin tear short term care plan. (ii) Care plans do not document the following interventions; a) one dementia care resident with XXXXX, b) No behavioural assessment or nursing care plan for one hospital resident exhibiting aggressive and resistive behaviour as per progress notes, c) changes in dietary requirements for rest home resident with weight loss. The same resident has not had a pain assessment for XXXX on admission and for exacerbation of pain post fall. (iii) Two residents with chairbrief restraints did not have interventions documented to manage the risks identified, (iv) two residents with restraint removed through the assessment/evaluation process had contradictory interventions within the care plan.

#### **Corrective Action:**

(i) Ensure wound evaluations are completed at the required frequency, (ii) Ensure interventions are documented to reflect the resident's current needs.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

A team of activity coordinators implement a separate activity programme for the rest home, two hospital units (Canterbury and Wimbledon) and the dementia (special) care unit. The activity co-ordinators are trained to deliver the Triple A exercise programme. Support and on-going education provided by Ryman Leisure and Activities Manager. The activity team have current first aid certificates. The activity co-ordinator in the dementia unit has commenced diversional therapist training. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.

The rest home programme is from Monday to Friday and includes (but not limited to); newspaper reading, functional fitness, word games, board games, quizzes, craft, happy hour, nail and hand care and walks (individual and group walks) and Triple A exercise and challenges. The rest home van is available for the weekly outings

Each hospital unit has an activity co-ordinator to implement the hospital activity programme from Monday to Sunday. The programmes includes (but not limited to); newspaper reading, library trolley, reading group, housie, indoor bowls, balloon exercise, functional fitness, happy hour, movies and music. Daily contact is made and one on one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. A mobility taxi is hired twice weekly for outings for hospital residents.

There is a separate activity programme for the special care unit. There is a full time activities co-ordinator who is supported by part time staff to provide an activities program 9am to 8pm Monday to Sunday. Residents in the dementia care unit are taken for supervised outdoor walks and scenic drives. Activities in the dementia unit are individualised and based on sensory activities and normal daily activities. Three relatives interviewed are complimentary about the activities and outings provided for the dementia care residents.

Entertainment includes musical groups and individuals and ethnic groups such as the Israeli folk dance group. Volunteers include family members who sing and entertain. There is a visiting pet group with small dogs. Special events are celebrated such as Father's day recently with a trip to the air force museum. Six churches rotate their services weekly. There is a men's club held regularly with guest speakers from the community and interest groups. The service has commenced weekly Farmers Market days that the residents enjoy attending and the community are invited to attend.

The resident/family/whanau as appropriate completes a "Life experiences" information sheet. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. The plan includes categories for comfort and wellbeing, outings, interests and family and community links.

Resident meetings are held to monthly in all units.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)**

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

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

**Attainment and Risk:** FA

**Evidence:**

The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). Short term care plans are utilised in the rest home, hospital, and dementia unit. Short term care plans are evaluated regularly and resolved or added to the long term care plan if an on-going problem (link 1.3.6.1). Any changes to the long term care plan are dated and signed. Family are invited to attend the multidisciplinary review meetings. Resident medications and medical status are reviewed at least three monthly by the general practitioners.

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

D 16.3c: Thirteen of 13 initial care plans (six hospital, three rest home and four dementia care) have been evaluated by the RN within three weeks of admission.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)**

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

**Attainment and Risk:** FA

**Evidence:**

There is a referral policy. Referral to other health and disability services is evident in the sample group of 13 resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated by the service. The clinical manager and two unit co-ordinators and three RN's interviewed state they initiate referrals to nurse specialist services. When the referral is to be made to a specialist a letter from the GP is then required. Referrals and options for care are discussed with the family. Referrals sighted on the resident files sampled are as follows: physiotherapy, needs assessor, dietitian, geriatrician, mental health services for the older person, diabetes clinic, diabetic retinopathy, ultrasound, palliative care nurse, wound care nurse and consultant psychiatrist,

D 20.1 discussions with registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists.

D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed. One resident in the serviced apartment was assessed for rest home level of care. Another resident from the dementia care unit was re-assessed for hospital level of care.

**Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)**

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

**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 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

**Attainment and Risk:** FA

**Evidence:**

Transfer information is completed by the registered nurse or clinical manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. The transfer of residents or admission to other provider's policy includes instructions for documentation and whom to notify. One of four dementia care resident files reviewed, identified transfer documentation has been completed by the RN and family notified for an acute transfer to hospital. Three RNs interviewed could describe the required transfer documentation including the yellow envelope system used by the district health board. Relatives (five hospital, three dementia care) interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.

**Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)**

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:****Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)**

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

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

**Attainment and Risk:** PA Moderate**Evidence:**

The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. The service uses individualised medication blister packs for regular and PRN medications. Medications are checked on delivery against the medication chart and the RN signs the back of the blister pack to verify the medications have been checked. PRN medications are renewed every three months.

Three medication rooms are viewed (rest home, hospital and special care unit) and one medication cupboard (serviced apartments). All medications rooms are secure and medications trolleys are locked. Trolley contents are all within expiry dates and eye drops are dated on opening. Expiry dates of medication in stock are checked monthly. There is an improvement required around expiry dates of emergency medications.

Enrolled nurses and caregivers administer medications in the serviced apartments, rest home and special care unit. RNs only administer medications in the hospital unit. Staff attend medication administration training annually and completed annual medication and insulin competencies. RNs have complete syringe driver training and maintain competency with annual refreshers. Standing orders are used. There is an improvement required around the standing orders. There is one resident in the rest home that is self-medicating. The resident has a self-medication assessment that is reviewed three monthly and self-administering of medications is monitored by the staff. There is an improvement required around self-medicating residents in the serviced apartments. Medication fridges have temperature recordings completed weekly. A corrective action has been raised (prior to audit) regarding low temperature control in the hospital medication fridge and this is being monitored.

Controlled drugs safes are located in the medication rooms for each unit. Controlled drugs for the residents in serviced apartments is accessed from the hospital controlled drug safe. There are weekly controlled drugs checks sighted in the controlled drug registers. The pharmacy undertake a six monthly controlled drug stocktake last completed June 2014. The hospital holds a stock of palliative medications. All controlled drugs are prescribed for individual use. Medications to be returned to the pharmacy are stored securely until collected by the pharmacy. Oxygen and suction hospital unit is checked and signed off weekly.

Medication administration is observed to be compliant as observed in the rest home dining room on the day of audit. There are no gaps identified on the 26 medication signing sheets reviewed. PRN medications have the date and time of administration on the signing sheet. Controlled drugs signing sheets are signed by two persons. Eye drops are not administered as prescribed for one rest home resident in the serviced apartments.

Twenty six medication charts sampled (12 hospital, four rest home, two rest home in serviced apartments and eight dementia care) record prescribed medications by residents' general practitioner. There are improvements required around discontinued medications and indications for use of PRN medications. All medication charts have photo identification (dated) and allergies/adverse reactions documented.

D16.5.e.i 2; Twenty six medication charts reviewed identified three monthly medication reviews signed by the attending GP.

**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 Moderate

**Evidence:**

Enrolled nurses and caregivers administer medications in the serviced apartments, rest home and special care unit. RNs only administer medications in the hospital unit. Staff attend medication administration training annually and completed annual medication and insulin competencies. RNs have complete syringe driver training and maintain competency with annual refreshers. Standing orders are used.

All medications rooms are secure and medications trolleys are locked. Trolley contents are all within expiry dates and eye drops are dated on opening. Expiry dates of medication in stock are checked monthly.

Medication administration is observed to be compliant as observed in the rest home dining room on the day of audit. There are no gaps identified on the 26 medication signing sheets reviewed. PRN medications have the date and time of administration on the signing sheet. Controlled drugs signing sheets are signed by two persons

Twenty six medication charts sampled (12 hospital, four rest home, two rest home in serviced apartments and eight dementia care) record prescribed medications by residents' general practitioner. All medication charts have photo identification (dated) and allergies/adverse reactions documented.

**Finding:**

1) The standing orders have not been signed by the GPs. (Advised that standing orders are reviewed annually and sent out in July RAP programme); 2) One XXXX injection in the hospital medication fridge expired December 2013. 3) Twice daily eye drops for rest home resident in serviced apartments have not been documented as administered. 4) Discontinued medications on seven (2 hospital, two rest home and three dementia) medication charts have not been signed by the GP. There are no indications for use of PRN medications on three (one hospital and two dementia) out of 26 medication charts.

**Corrective Action:**

1) Ensure standing orders are valid. 2) Ensure emergency medications are within expiry dates. 3) Administer medications as prescribed. 4) Ensure discontinued medications are signed by the GP, Ensure PRN medications have an indication for use.

**Timeframe (days):** 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

**Attainment and Risk:** FA

**Evidence:****Finding:****Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is one resident in the rest home that is self-medicating. The resident has a self-medication assessment that is reviewed three monthly and self-administering of medications is monitored by the staff

**Finding:**

There are two residents in the serviced apartments who self-medicate a) eye drops and b) laxatives. Competency assessments for self-medication have not been completed. There is no monitoring of the self-medicating residents.

**Corrective Action:**

Ensure self-medicating residents are competency assessed and monitored as per protocol.

**Timeframe (days):** 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.12.6 (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:**

The service employs a qualified chef Sunday to Thursday, a part time chef for Friday and Saturdays is being recruited and the position is being filled by bureau staff. The chef is new and is supported by a team of 16 staff. There is a four weekly seasonal menu that has been designed and reviewed June 2014 by a dietitian at organisational level. The chef receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly review and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are written on the dietary profiles. Normal, mouli and diabetic diets and gluten free diets are provided. Food is delivered in hot boxes to the kitchenettes in each area and served from bain maries. RNs, Manager, Activities co-ordinators and caregivers serve the meals and have a resident like/dislike list in each dining area. The chef plates and labels special diets. Nutritious snacks such as desserts, yoghurt, custard, biscuits and sandwiches are available over 24 hours for residents in the dementia unit. Staff are observed sitting with the resident when assisting them with meals.

The service has a large workable kitchen with a separate dishwashing area, baking, cooking and storage areas, a chiller, fridges and freezers, walk-in pantry, two combi ovens and electric stove. All foods are date labelled in the freezers and fridges. Dry goods in the pantry are sealed and date labelled. There is a three monthly clean of the large dry goods bins. Fridge and freezer temperatures are recorded weekly and there is evidence of corrective action taken where temperatures are outside of the accepted range. Hot food temperatures are recorded in the kitchen as per Ryman policy. There is a cleaning schedule in place (sighted) which is signed off as duties are completed. Staff are observed wearing aprons, hats and gloves.

The kitchen equipment is on a planned maintenance schedule. The preferred supplier provides chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. Chemicals are stored safely in the kitchen.

There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal

Feedback on the service is received from resident and staff meetings, surveys and audits.

E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.

D19.2: Staff have been trained in safe food handling and chemical safety annually.

#### 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:** FA

**Evidence:**

There are implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry, housekeeping and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety data sheets are available.

### 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:** 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 1.4.1.6 (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:** FA**Evidence:**

The two buildings have a current building warrant of fitness that expires 1 December 2014. The service is divided into two buildings. Eighty hospital beds are divided into two units of 40 beds each (Wimbledon and Canterbury). Serviced apartments are located in the same building. The rest home and dementia care units are in another building that is easily accessible by a connecting pathway. The service has a chapel, library service, hairdressers and shop for all residents to access.

The maintenance team address any maintenance requests or call in contractors as required. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists (January 2014) and electrical testing. An appliance asset list is maintained for facility and resident electrical equipment. Each unit has its own water supply with tempering valves on each cylinder. Hot water temperatures in resident areas are monitored monthly and stable between 43-45 degrees Celsius.

The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.

There is a team of grounds and garden staff that maintain the external areas. Residents are able to access the outdoor gardens and courtyards safely from all units. Seating and shade is provided.

E3.4d. the lounge area is designed so that space and seating arrangements provide for individual and group activities. The dining and lounge area is open plan however can be separated if necessary.

ARC D15.3; The nine caregivers, three registered nurses, one enrolled nurse and two unit co-ordinators interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including the following equipment; sensor mats, sensor light and bed sensor pads (dementia care unit), standing and lifting hoists, tilting shower chairs, hospital level lounge chairs, mobility aids, transferring equipment, wheel-on and chair scales, pressure relieving mattresses and cushions, electric beds and ultra-low beds

E3.3e: There are quiet, low stimulus areas that provide privacy when required.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 1.4.3: 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:**

All bedrooms in the units have ensuites. There are adequate numbers of communal toilets located to the communal areas. Toilets have privacy locks. Residents interviewed (six hospital and three rest home) confirmed their privacy is assured when staff are undertaking personal cares. The serviced apartments assessed as part of this audit included mobility en-suites.

### **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:**

All residents rooms are single and of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents are encouraged to personalise their bedrooms.

The serviced apartments assessed as part of this audit were spacious and allowed for the use of mobility aids.

#### 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:**

Each unit has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library area available for quiet private time or visitors. The communal areas are easily and safely accessible for residents and staff.

E3.4b: There is adequate internal and external space to allow maximum freedom of movement while promoting safety for those that wander. The dementia care unit has an open courtyard with safe paving and walkways with entry and exit points within the secure facility. There is seating and shaded areas. There are raised gardens and vegetable gardens.

#### **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 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 chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. A chemical spills kit is available. Laundry chemicals are within a closed system to the washing machines. Material safety data sheets are readily accessible.

There are two laundry persons on duty each day. All linen and personal clothing is laundered on-site. The laundry and cleaning areas have hand-washing facilities. Cleaner's trolleys are well equipped. All chemical bottles have the correct manufacturer's labels. The cleaning service has a vax/shampoo machine for spot cleaning and commercial carpet cleaners are contracted for full carpet clean throughout the facilities. Residents (three rest home and six hospital) interviewed state they are happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing is treated with care and is returned to them in a timely manner. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits.

**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.

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

**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.

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

**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 D15.3j; D19.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> 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. Anthony Wilding has an approved fire evacuation plan – letter dated 7 December 2006. Fire drills are scheduled for staff

during induction and six monthly. The fire drill in May 2014 resulted in an 87% audit outcome. A fire drill was scheduled 1 July 2014 with an improvement in response rate. Fire training was completed in April 2014. Smoke alarms, sprinkler system and exit signs are in place.

As per Ryman policy, staff are required to complete emergency response training every two years and emergency procedures are included in orientation. There is a first aid trained staff member on every shift. There are emergency flip charts predominantly displayed in staff areas.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.

The service has alternative cooking facilities (two barbeques) 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. The service has a written agreement with a local hire company and food supplier that in the event of an emergency essential equipment such as generators and food supplies will be delivered. Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. Senior caregivers carry a pager and all calls are signalled on a screen with the room number at varied places throughout the facility. Due to the large size of resident rooms, a wireless call bell system has been installed so that call bells are in reach of residents sitting in armchairs in their rooms. In the dementia units the "Austco 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 lights in resident rooms which illuminate depending on the location of the resident in the room. This is controlled by a timer, so can be set to meet the needs of individual residents. The serviced apartments also include call bells in resident rooms and ensuites. Those residents assessed as requiring rest home level care in the serviced apartments are given a call bell pendant so that a call bell is always accessible. There is an entrance and reception area on entering the main building. The entire facility is secured at night. There is secure entry/exit to the dementia unit.

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service currently has 12 hospital residents who have been assessed as requiring the use of bedrails and/or chairbrief's and one hospital resident with an enabler (bedrails). A monthly restraint and enabler register is maintained. The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation (link 1.3.6.1). There are restraint monitoring guidelines in place.

Restraint minimisation and enabler use is discussed at the RAP management meetings and six monthly restraint meetings. The GP is involved in the restraint approval and review process. The coordinator of the hospital (RN) is the restraint officer. Types of restraint have been approved for use by the restraints committee. The service is able to evidence a successful trial of removal of restraint for four residents recently. Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice is included in the core competencies and dementia course modules.

#### **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.)*

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

### **Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)**

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint officer is the hospital unit coordinator (registered nurse). The restraint officer has completed restraint training. There is a restraint officer's job description. The approved restraints (bedrails and chairbrief) are documented in the restraint policy. Restraint and consent is in consultation/partnership with the resident (as appropriate) or whanau, the restraint officer, and GP. There is provision for emergency restraint following consent from family/whanau.

### Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint 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 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Restraint assessments are undertaken by the restraint officer or registered nurse in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the resident/family/whanau and GP. Three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form, three month reviews and six monthly documented devaluations (link 1.3.6.1).

All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed by the Restraint officer and restraint committee.

### Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;

- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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

### **Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)**

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Monitoring and observation process is included in the restraint minimisation policy. There are approved restraints documented in the policy. There is a specific restraint section of the overall resident VCare care plan that includes interventions and care required (link 1.3.6.1). Falls risk and challenging behaviour assessments are completed. A restraint register is in place. There is an assessment form/process that is completed for all restraints. Three files were reviewed, all three had completed assessment form, care plan interventions did not all include those listed in the assessment (link 1.3.6.1). Monitoring forms include regular monitoring and cares provided. A three monthly evaluation of restraint is completed that reviews the restraint episode. Restraint in use is part of falls prevention and for safety and security measures.

**Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)**

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)**

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

**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 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)**

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint 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 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)**

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Three monthly reviews are completed as evidenced in the three files reviewed. Written evaluations are also completed by the restraint co-ordinator/RN at least six monthly or earlier if required as part of the three monthly medical review. Families are included in restraint review as part of the long term care plan review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and restraint committee. Individual restraint use is monitored and recorded by care staff.

#### **Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)**

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;

- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education 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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)**

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

**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 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

Individual approved restraint is reviewed at least three monthly and six monthly as part of the long term care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint officer. Incident/accidents are reviewed by the restraint officer. Corrective actions are monitored. There is a monthly restraint officer report (including the hours of restraint) is sent to head office. Restraint is discussed at the six monthly restraint meeting, monthly RN meeting and management meetings. Restraint use is linked to the Ryman Accreditation programme (RAP). Individual restraint use is monitored and recorded by care staff.

### Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

**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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description. There is an implemented infection control programme that is linked into the quality management system. Infection control matters are integrated with the bimonthly health and safety meetings and the infection control committee includes a cross section of staff (link 3.5). The facility meetings – RAP committee, staff, registered nurse, full facility, management - also include a discussion and reporting of infection control matters. The IC programme is set out annually from head office and is directed via the RAP annual calendar. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control committee is made up of a cross section of staff from areas of the service. The infection control committee is combined with the health and safety committee. The IC Officer is an enrolled nurse (with support by the clinical manager) and she has completed online IC training through MOH. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation

### Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

**Attainment and Risk:** FA

**Evidence:**

There are comprehensive infection control policies that are current and reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practise. These are across the Ryman organisation and are current and regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate. There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) IC policies and procedures related to the prevention of transmission of infection.

### Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

### **Standard 3.4: Education (HDS(IPC)S.2008:3.4)**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control officer is responsible for coordinating/providing education and training to staff. The IC officer (enrolled nurse with support from the clinical manager) has appropriate IC training for the role (Ministry of Health online training – March 2014). The induction package includes specific training around hand washing and standard precautions and the IC officer provides training both at orientation and on-going. Training on infection control was last provided Sept 2014 (76 attended), Outbreak management June 2014 (21 attended). Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the RAP. The results are subsequently included in the village manager's report. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

**Improvement Note:**

The service is over-recording the number of infections in their stats. The service should consider reviewing the benchmarking definitions to ensure only the infection is documented and not repeated when an antibiotic is changed.

**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.)*