# Shona McFarlane Retirement Village Limited

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Shona McFarlane Retirement Village Limited

**Premises audited:** Shona McFarlane Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 13 January 2015 End date: 14 January 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 72

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

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

## General overview of the audit

Shona McFarlane Retirement Village is a Ryman Healthcare facility, situated in Lower Hutt. The facility provides rest home and hospital level care. On the day of audit there were 31 rest home residents and 42 hospital residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, and staff.

The village manager is suitably qualified and is supported by a clinical manager (registered nurse) and an assistant village manager. There are systems in place that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme (RAP).

Two continuous improvement ratings have been awarded around implementation of quality improvement plans and the activities programme.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| 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. |

Shona McFarlane provides care in a way that is focused on the individual resident’s quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment has been undertaken on admission and during the review process. Policies were being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was readily available to residents and families. Care plans accommodated the choices of residents and/or their family. Informed consent was sought and advanced directives were appropriately recorded. Complaint processes were being implemented and complaints and concerns were managed and documented. Residents and family interviewed verified on-going involvement with the community.

## Organisational management

|  |  |  |
| --- | --- | --- |
| 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. |

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

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is comprehensive service information available. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations were completed by the registered nurses within the required timeframe. Care plans demonstrated service integration, were individualised and evaluated six monthly. Care plans, written evaluations, assessment tools and monitoring forms were completed and updated on the on-line system. Copies of care plans were available for care staff. The residents and family interviewed confirmed they were involved in the care planning and review process. Short term care plans were in use for changes in health status. The activity coordinators provide a separate activities programme for rest home and hospital residents. The programme ensures the individual abilities and recreational needs of the resident are met.

Staff responsible for medication administration have completed annual competencies and education. There were three monthly GP medication reviews.

Meals are prepared on site. The menu was designed by a dietitian at organisational level. Individual and special dietary needs are catered for. Alternative options were provided. Additional desserts were provided in the hospital unit for weight management. Residents interviewed responded favourably to the meals provided.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| 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. |

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms were single and have en-suites. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed on-site.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There are comprehensive policies and procedures that meet the restraint standards. There is a restraint co-ordinator with delegated responsibilities for monitoring enabler/restraint use and compliance of assessment and evaluation processes. Enabler and/or restraint use was discussed at approval committee and clinical meetings. There was on-going restraint and challenging behaviour education evident. There were no residents requiring restraint at the time of audit. There were six residents using an enabler.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection control programme is appropriate for the size and complexity of the service. The infection control officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer had attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer used the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 44 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 91 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents were provided with information on admission which included the Code. Staff received training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interview with 16 care assistants (15 who work across the care centre and one from the serviced apartments) demonstrated an understanding of the Code. Residents interviewed (three rest home and three hospital) and relatives (three rest home and one hospital) confirm staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes have been discussed with residents and families on admission. Written general and specific consents were evident in the nine resident files sampled (five hospital and four rest home). Care assistants and registered nurses interviewed confirm consent is obtained when delivering cares. Resuscitation orders for competent residents were appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.  Discussion with family members identifies that the service actively involves them in decisions that affect their relative’s lives. Nine admission agreements (seven permanent and two short stay) sighted were signed within the required timeframe. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents’ family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents were assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisational complaints policy is being implemented at Shona McFarlane. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. A feedback form was completed for each complaint recorded on the complaint register. There is a complaints register maintained that included relevant information regarding the complaint. Documentation including follow up letters and resolution were available. Verbal complaints were included and actions and response documented. The number of complaints received each month were reported monthly to staff via the various meetings. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Feedback forms were available for residents/relatives in various places around the facility. A complaints procedure was provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives informed information had been provided around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The village manager described discussing the information pack with residents/relatives on admission. 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. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of Shona McFarlane confirmed there were areas that 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. Staff could describe definitions around abuse and neglect that align with the Ryman policy. An annual resident satisfaction survey had been completed and the results showed the overall resident experience is reported as being good or very good (84%). The relative survey completed showed 91% of respondents rated the service as good or very good.  The service has a philosophy that promoted quality of life and involved residents in decisions about their care. Resident preferences were identified during the admission and care planning process with family involvement (nine files reviewed). Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.  Interview with care assistants described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | Ryman has a Maori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that 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 reported there were no residents that identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out where the resident and/or whanau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, duty manager and three registered nurses confirmed an awareness of professional boundaries. Care assistants could discuss professional boundaries in respect of gifts. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | All Ryman facilities have a master copy of policies which have been developed in line with current accepted best and are reviewed regularly. The content of policy and procedures are sufficiently 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 was being collected at Shona McFarlane against each the two service levels, and reported through to head office for monitoring. Indicators include (but not limited to): falls, medication errors and infections. Feedback on incident trending was provided to staff via the various meetings as determined by the Ryman Accreditation Programme (RAP). Quality Improvement Plans (QIP) are developed where thresholds exceed expectation e.g. QIP for falls was sighted. VCare is the electronic system used by all sites to report relevant information through to head office, and is seen to be used at Shona McFarlane.  Services are provided at Shona McFarlane that adhere to the health & disability services standards. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Shona McFarlane is moving to electronic reporting of incidents into the Ryman system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Shona McFarlane is a Ryman Healthcare retirement village. The service provides rest home and hospital level care for up to 79 residents in the care centre. Twenty serviced apartments have previously been certified as suitable to provide rest home level care. There were 72 residents in the facility on the day of audit including 31 rest home (of which one was in a serviced apartment) and 42 hospital level residents. There is a contracted physiotherapist that provided 15 hours a week, and a contracted medical centre providing general practitioner services.  Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the RAP. Shona McFarlane was in the process of confirming 2015 objectives at the time of audit.  The village manager at Shona McFarlane has been in the role for approximately two and a half years, and has worked with Ryman for an estimated 16 years. She is supported by an assistant manager who carries out administrative functions and a clinical manager (registered nurse) who oversees clinical care. The clinical manager has been in post for two years and has previous experience within the aged residential care sector (absent during the audit). The management team is supported by the wider Ryman management team including a regional manager. The village manager and clinical manager have maintained at least eight hours to date of professional development activities related to managing a village. |
| Standard 1.2.2: Service Management  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. | FA | During a temporary absence, the assistant manager and clinical manager covers the manager’s role. The assistant manager covers administrative functions and clinical manager clinical care. The regional manager provides oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Shona McFarlane is implementing the Ryman Accreditation Programme (RAP) which links key components of the quality management system to village operations. The RAP Committee meet monthly. Outcomes from the RAP Committee are reported across the various meetings including the full facility, registered nurse and care assistants. Meeting minutes include discussion about the key components of the quality programme.  Policy review is coordinated by Ryman head office. Facility staff have the opportunity to provide feedback during the review process. Policy documents have been developed in line with current best and/or evidenced based practice. Facilities have a master copy of all policies and procedures and the related clinical forms. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to be completed to maintain competence. The surveys have been completed by the various staff groups.  The RAP prescribes the annual internal audit schedule that was being implemented. Audit summaries and QIPs are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee e.g. RAP, health and safety.  Monthly clinical indicator data is collated across the rest home (including rest home residents in the serviced apartments) and hospital services. There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets – e.g. falls. Falls prevention strategies are in place. QIP’s have also been developed to address issues raised through the 2014 resident/relative survey. QIP’s reviewed are seen to have been closed out once resolved. Interview with staff confirmed an understanding of the quality programme.  Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Shona McFarlane had four defined quality objectives for the 2014 year. The QIP process is used to plan and evaluate progress towards village specific objectives. Shona McFarlane was in the process of confirming 2015 objectives at the time of audit. The service has been awarded a continuous improvement in respect of the work completed against two of the four 2014 objectives.  There is a health and safety, and risk management programme being implemented at Shona McFarlane. The combined health and safety and infection control committee met bimonthly and included discussion of incidents/accidents and infections. There is a safety representative who has attended training. There was a current hazard register. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Shona McFarlane collects incident and accident data and was in the process of moving from manual to electronic recording of events. Electronic and hard copy incidents were reviewed and all had been completed with appropriate clinical follow up. Monthly analysis of incidents by type has been undertaken by the service and reported to the various staff meetings. Data was linked to the organisation's benchmarking programme and used for comparative purposes. QIPs were created when the number of incidents exceeded the benchmark – e.g. falls. QIPs were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are also job descriptions for all roles. Appropriate recruitment documentation was seen in the 12 staff files reviewed. A register of practising certificates is maintained. Performance appraisals are current in all files reviewed. Interview with the management team (village manager and assistant village manager) inform a stable workforce. The clinical manager was unavailable during the audit. Interview with care assistants and registered nurses inform management are supportive and responsive.  There is an annual training plan aligned with the RAP that was being implemented. There is an enrolled nurse who oversees staff participation in the ACE programme which is a requirement for care assistants. Ryman ensures registered nurses (RN) are supported to maintain their professional competency. There is an RN journal club that meets two monthly at Shona McFarlane. Ryman has a 'Duty Leadership' training initiative that all registered and enrolled nurses and senior leaders complete.  There is an induction programme being implemented with completion being monitored and reported monthly to head office as part of the RAP programme. Interview with staff informed the induction programme meets the requirements of the service. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a fulltime clinical manager, and a duty manager who works three days per week. There was an enrolled nurse coordinator working in the serviced apartments (where there was one rest home resident at the time of audit). There is at least one registered nurse and first aid trained member of staff on every shift. Interviews with care assistants informed the registered nurses are supportive and approachable. In addition they reported there are sufficient staff on duty at all times. Interviews with residents and relatives also indicated there are generally sufficient staff to meet resident needs. Agency staff can be used to cover unexpected absences. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard in both areas. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries reviewed were legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The clinical manager screened all potential residents prior to entry to services to confirm they meet the level of care provided at the facility. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Transfer information has been completed by the registered nurse’s or clinical manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. RNs interviewed could describe the required transfer documentation including the yellow envelope system used by the district health board. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| 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. | FA | All medication has been managed appropriately in line with required guidelines and legislation. RNs and care assistants responsible for the administering of medication have completed annual medication competencies and attended annual medication education. The service uses individualised medication blister packs for regular and PRN medications. Medications have been checked on delivery against the medication chart. Medication trolley contents were all within expiry dates and all eye drops were dated on opening. There were no self-medicating residents. The standing orders in use are current. Medication administration practice was observed to be compliant. As required medications have the date and time of administration on the signing sheet. Eighteen medication charts sampled (10 hospital, eight rest home) meet legislative prescribing requirements.  D16.5.e.i 2; Eighteen medication charts reviewed identified three monthly medication reviews signed by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a qualified cook Monday to Friday and a weekend chef. They are supported by a cook assistant and kitchen hand each day. There was a four weekly seasonal menu that had been designed and reviewed June 2014 by a dietitian at an organisational level. The cook receives a resident dietary profile for all new admissions and has been notified of dietary changes following six monthly reviews and at other times such as resident with weight loss/weight gain or swallowing difficulties. Specific cultural preferences were met. Resident likes, dislikes and dietary preferences were known. There were two meal options identified on the menu for the evening meal. Evening meal desserts had been successfully introduced in the hospital wing for the management of weight loss (refer CI 1.2.3.7). Food is delivered in hot boxes to each area. Staff were observed sitting with the residents when assisting them with meals. The service is well equipped. The freezer temperature is checked weekly. The walk-in chiller is checked daily. Food temperatures are monitored twice daily and recorded. Al foods were date labelled. A cleaning schedule is maintained. Feedback on the service was received from resident and staff meetings, surveys and audits.  D19.2: Staff have been trained in safe food handling and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | 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 was referred back to the Needs Assessors or referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission.  Risk assessment tools were sighted as completed and reviewed at least six monthly or when there was a change to a resident’s health condition. Care plans reflected the outcome of the risk assessments for the nine resident files sampled. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Nine of nine files reflect the outcome of nursing assessments and describe the interventions required to meet the resident needs. Resident/family/whanau involvement in the care planning process was evidenced by signatures on the written acknowledgment of care plan form in the resident files sampled. Residents and relatives interviewed confirmed they were involved in their care plans.  D16.3k, Short term care plans were in use for changes in health status.  D16.3f; Resident files sampled identified that the resident/family were involved in the development/evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. Relatives interviewed stated their relative’s needs were being appropriately met. 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 were sighted in the resident’s files.  D18.3 and 4: Dressing supplies are available and treatment rooms were adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency for two chronic wounds, linked to the long term care plans. Pressure area cares and interventions were documented in the long term care plans. The RNs interviewed have access to an external wound specialist as required. The GP reviews the wounds three monthly or earlier if 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 interviewed.  Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts. |
| Standard 1.3.7: Planned Activities  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. | CI | A team of activity coordinators (six) implement a separate activity programme for the rest home and hospital wings. All have a current first aid certificate. The Ryman ‘Engage’ programme is delivered Monday to Sunday. The activity co-ordinators have been trained to deliver the Triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group.  Activities were observed to be delivered simultaneously in the rest home and hospital wings. There are a number of “village friends” (volunteers) who are involved in the programme including one on one visits to residents. 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.  The resident/family/whanau as appropriate complete a “Life experiences” information sheet. Activity plans have been developed and residents have been encouraged to join in activities that are appropriate and meaningful. Resident meetings were held three monthly and open to families to attend.  D16.5d. The activity plans reviewed have been evaluated at the same time as the clinical care plans. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The written evaluation template describes progress against every goal and need identified in the care plan. D16.4a Care plans reviewed were evaluated six monthly or more frequently when clinically indicated.  Short term care plans were utilised and evaluated regularly.  Family were invited to attend the multidisciplinary review (MDR) meetings. The physiotherapist, GP, activity co-ordinator and care staff were involved in MDR meetings.  D 16.3c: All initial care plans sighted had been evaluated by the RN within three weeks of admission. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The duty leader (RN) and RN's interviewed stated they initiate referrals to nurse specialist services. Specialist referrals were made by the GP. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes.  D 20.1 Discussions with registered nurses identified that the service has access to appropriate allied health providers.  D16.4c; The service provided examples of where a residents condition had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets were available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 8 March 2015. The service is divided into two units - Tulip (hospital) and Sunflower (rest home and dual purpose beds). There is a nurse’s station within each unit.  The full-time maintenance person addresses daily maintenance requests. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of electric beds and hoists (July 2014). The service has a trained electrical tester and equipment to carry out annual electrical testing. Hot water temperatures in resident areas have been monitored and stable between 43-45 degrees Celsius. Contractors are available 24/7 for essential services.  The facility has wide corridors with sufficient space for residents to mobilise using mobility aids.  The service employs grounds and garden staff that maintain the external areas. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. There is an outdoor designated smoking area.  ARC D15.3; The 16 care assistants and three registered nurses interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | All bedrooms in the units have ensuites. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents rooms are single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents have been encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each unit has a lounge and dining area. There are seating alcoves and family rooms available quiet private time or visitors. The communal areas are easily and safely accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits were completed as per the RAP programme. 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 for the laundry.  There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on- site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR has been included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Shona McFarlane has an approved fire evacuation plan and fire dills have occurred six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is in place for four hours. There are three civil defence kits in the facility and stored water. Call bells are in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. The service utilises security cameras and an intercom system. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight. |
| Standard 3.1: Infection control management  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. | FA | The infection control programme is appropriate for the size and complexity of the service. There is an infection control (IC) responsibility policy that includes chain of responsibility and an infection control officer job description. The infection control programme is linked into the quality management system via the RAP. The infection control committee is combined with the health and safety committee which has met bimonthly. The facility meetings also include a discussion of infection control matters. The IC programme is set out annually from head office and directed via the RAP annual calendar. The facility had developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control committee (combined with the health and safety committee) is made up of a cross section of staff from areas of the service including; (but not limited to) the village manager, the clinical manager (who is the IC officer); and maintenance. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation. |
| Standard 3.3: Policies and procedures  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. | FA | There are comprehensive infection control policies that were current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. These are across the Ryman organisation and are 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 |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control officer is responsible for coordinating/providing education and training to staff. The infection control officer (clinical manager) has appropriate training for the role. The induction package included specific training around hand washing and standard precautions and training was provided both at orientation and as part of the annual training schedule. Resident education was expected to occur as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are in place appropriate to the complexity of service provided. Individual infection report forms were completed for all infections and kept as part of the resident files. Infections were included on a register and a monthly report was completed by the infection control officer. Monthly data was reported to the combined infection control and health and safety meetings. Staff have been informed through the variety of meetings held at the facility. The infection control programme is linked with the RAP. The infection control officer has used the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. 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. During June and July 2014 a number of residents experienced a respiratory infection. This was reported to Public Health, but not formally called an outbreak. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The policy identifies that restraint is used as a last resort. The service was restraint free at the time of audit. There are currently six residents with the use of enablers (five lap belts and two bedrails). The restraint co-ordinator maintains a monthly enabler register. All six resident files sampled with enablers identified assessments and consents signed by the resident, GP and restraint co-ordinator. The restraint approval committee reviews the use of enablers six monthly. Enablers and identified risks were documented on the long term care plan. Staff document shift monitoring in the handover book and progress notes. The use of enablers/restraint was discussed at clinical meetings reviewed. Restraint use was included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education was provided. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

|  |
| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | CI | Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the RAP.  Shona McFarlane had four defined quality objectives for the 2014 year – Dining with Dignity, Thinking like a Nurse, Orientation Toolbox and Safe Work Practice. The QIP process had been used to plan and evaluate progress towards each objective. Progress towards objectives was seen to have been discussed at the various staff meetings. Two of the four objectives were considered to have been met (Dining with Dignity and Safe Work Practice) and the two remaining will continue through the 2015 year.  Shona McFarlane was in the process of confirming 2015 objectives at the time of audit. | Shona McFarlane had identified four quality improvement objectives for the 2014 year. Each had been developed in response to feedback received via resident/relatives and/or staff and included an aim and proposed method of achievement. This continuous improvement has been awarded based on the results achieved against two of the four objectives. A brief summary follows:  a) Dining with Dignity. The objective was established in respect of resident and relative feedback via the annual survey. The intent of the objective was to improve satisfaction with the quality of the food and the overall dining experience. Implementation included refurbishment of the two dining areas and use of table cloths versus place mats to differentiate between the midday and evening meal time. An alternative option for the evening meal was established where residents had a choice (they could have both options if they wish). In the hospital wing, a desert option was introduced to the evening meal. This was to ensure variety was added for those residents requiring a soft and/or moulied meal. Feedback via resident/relative meetings has been positive on the changes. Equally as significant has been the impact on resident weight – across the September to December period, six residents who were at risk of weight loss experienced a gain in weight (between 2% and 11%) as a result of the introduction of deserts at the evening meal.  b) Safe Work Practice. This objective was developed to reduce the number of staff work place accidents. This objective focused on moving and handling training and competent use of lifting equipment (i.e. Hoists) - competencies were current at the time of audit. Photographs were taken of ‘safe’ and ‘unsafe’ practices in respect of lifting and manual handling and were left in staff areas. The physiotherapist – who was actively involved in the project – developed a ‘traffic light’ concept with staff that described at a glance how to safely transfer a resident – i.e. Green meant the resident was independent with transfers, orange meant the resident required one staff member to assist, and red two person assist. The traffic lights were kept in each resident wardrobe (sighted). There have been two reported outcomes resulting from this project. Staff work place accidents – of all the work place accidents that occurred during 2014, 80% occurred between January and July, with a marked decline during the second half of the year (20% of total accidents). A similar picture was seen with resident falls with 62% of the total number of falls having occurred between January to June and dropping to 38% (of the total) in the second half of the year. |
| Criterion 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. | CI | Activities were observed to be delivered simultaneously in the rest home and hospital wings. There are a number of “village friends” (volunteers) who are involved in the programme including one on one visits to residents. 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. | The Engage programme implemented covers seven days a week in the rest home and hospital. The activity team (interviewed) stated there were more activities happening in the resident’s day as a result of separate engage programmes for the hospital and rest home. Activities were observed to be happening simultaneously in the rest home and hospital wings. There are a number of “village friends” (volunteers) who are involved in the programme including one on one visits to residents. The Engage programme has resulted in increased one on one time particularly for the hospital residents who are unable to participate in activities or choose not to be involved in group sessions. Residents (interviewed) stated they are involved in the programme and share ideas for activities, entertainment and outings. They especially enjoy the pet therapy sessions and variety of entertainers as well as being involved in crafts, games etc coordinated by the activity team. There has been an increase in the number of outings and drives for hospital residents with the hire of a mobility taxi twice weekly. |

End of the report.