

Shona McFarlane Retirement Village Limited

Introduction

This report records the results of a Surveillance 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](#).

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: 24 August 2016 End date: 25 August 2016
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:	70

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

Indicator	Description	Definition
Yellow	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
Red	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 is part of the Ryman Group of retirement villages and aged care facilities. Rest home and hospital care level care is provided for up to 79 residents in the care centre. Rest home care is also provided for up to 20 residents in serviced apartments. On the day of audit there were 32 rest home residents including one rest home resident in the serviced apartments and 38 hospital level of care residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

The service is managed by an experienced non-clinical village manager and experienced clinical manager/registered nurse. The residents and relatives interviewed spoke positively about the care and support provided.

An area for improvement at this audit was identified around the documentation and implementation of interventions.

Continuous improvement ratings have been maintained around quality improvement projects and the engage activity 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.
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Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents and families. Documentation evidenced open disclosure is practiced. Complaint processes are being implemented and complaints and concerns are managed appropriately.

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.
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The team at Shona McFarlane is implementing the team Ryman 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 has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Shona McFarlane provides clinical indicator data for the two services being provided (hospital and rest home). There are human resources policies including recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three monthly.

The activity team provides an activities engage programme, which is varied, interesting and covers the seven-day week. The engage programme meets the abilities and recreational needs of the group of residents including a men's group.

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. The general practitioner reviews medications three monthly.

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food that is provided.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness.

Restraint minimisation and safe practice

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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There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager/restraint coordinator oversees restraint/enabler usage within the facility. The service currently has four residents voluntarily using enablers. The restraint coordinator maintains a register.

Infection prevention and control

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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The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six monthly comparative summary is completed. The service has had one outbreak since the last audit that was well managed.

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	14	0	1	0	0	0
Criteria	2	36	0	1	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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. The facility has an up-to-date complaints register. Concerns and complaints are discussed at relevant meetings. There have been four complaints made within the last year. One complaint received at the Health and Disability Commissioner office had been referred back to the facility for investigation. Investigation notes, follow-up letter and corrective actions were sighted and evidence appropriate complaints management in line with Right 10 of the Code. Discussion with residents (three rest home and one hospital) and relatives confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Incidents reviewed on the VCare system met this requirement. Three family members interviewed (one rest home and two hospital) confirmed they are notified following a change of health status of their family member. Resident meetings are held two monthly and relative meetings six monthly. There was an interpreter policy and contact details of interpreters were available.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Shona McFarlane Retirement Village is a Ryman Healthcare facility. The service provides care for up to 79 residents in the care centre at hospital and rest home level of care. All 79 beds are dual purpose. There are 20 serviced apartments certified to provide rest home level of care. On the day of audit, there were 70 residents - 38 hospital level residents and 32 rest home residents, including one rest home resident in serviced apartments and one resident on respite care. There was one hospital resident under 65 years under a long-term chronic health condition contract. All other long-term residents were under the ARC agreement.</p> <p>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. Quality objectives for the 2015 year have been reviewed and 2016 objectives in place. There is a health and safety, and risk management programme being implemented at Shona McFarlane.</p> <p>The village manager (non-clinical) has been in this role four years and has had a total of 18 years with Ryman. A full-time clinical manager was appointed in June 2015. She has 19 years clinical/surgical experience and this is her first appointment to aged care. She is supported by a hospital coordinator who was appointed in September 2015. The hospital coordinator has worked at Shona McFarlane as a registered nurse (RN) for the last 5 years. Management are supported by a regional operations manager.</p> <p>The village manager and clinical manager have attended a two day Ryman conference and leadership programme in the last year.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Shona McFarlane service continues to implement the teamRyman Programme, which links key components of the quality management system to village operations. There are full facility teamRyman meetings monthly. Outcomes from the teamRyman committee are then reported across the various meetings including the full facility, RN and care assistant meetings. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings with the head of departments are held weekly. Health and safety and infection control meetings are held three monthly. Clinical meeting minutes were sighted. Interviews with staff confirmed an understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. 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 complete to maintain competence. Care staff stated they are made aware of any new/reviewed policies.</p> <p>A resident survey was last completed in February 2016 and relative survey March 2016. Results have been</p>

		<p>collated with annual comparisons for each service. Areas of increased resident satisfaction are evident in the results around laundry service, activity programme, care and communication. Results are fed back to the participants at meetings.</p> <p>TeamRyman has an annual internal audit schedule that has been implemented at Shona McFarlane. Internal audit summaries and quality improvement plans (QIPs) are completed where a noncompliance is identified (<90%). Issues and outcomes are reported to the appropriate committee (eg, health and safety). QIPs reviewed are seen to have been closed-out once resolved. The service has maintained a continuous quality improvement focus and has exceeded the standard in this area.</p> <p>Monthly clinical indicator data is collated across the care centre (including any rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets (eg, falls). 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. The service has nominated a new health and safety officer who has been in the role six weeks. The health and safety officer has attended a health and safety training course including an update to the new legislation. The combined health and safety and infection control committee meet bi-monthly and incidents/accidents and infections are reviewed, discussed and documented. There is a current hazard register. The service has completed a self-assessment for tertiary level of the ACC workplace safer management practices.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>The service collects monthly incident and accident data and completes electronic recording of events on the VCare system. Monthly analysis of incidents by type is undertaken and is reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Quality improvement plans have been created when the number of incidents exceeded the benchmark. Ten accident incident forms reviewed (four hospital and five rest home) identified timely RN assessment and post falls assessments where required. Quality improvement plans (QIPs) were seen to have been actioned and closed out.</p> <p>Management were aware of the requirement to notify relevant authorities in relation to essential notifications. There has been one notification to public health and the DHB in August 2015 for an outbreak.</p>
Standard 1.2.7:	FA	There are organisational policies to guide recruitment practices and documented job descriptions for all positions.

<p>Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>There are job descriptions for designated officers. Appropriate recruitment documentation was seen in the eight staff files (one rest home coordinator/registered nurse (RN), one clinical leader/RN, two RNs and three caregivers and one health and safety officer) reviewed. Performance appraisals are current in all files reviewed. Interview with five caregivers inform that management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation followed by an eight-week assessment. A register of current practising certificates is maintained for RNs and all allied health professionals involved in the service.</p> <p>There is an annual training plan that is being implemented aligned with the teamRyman programme. Individual staff comprehension surveys are completed to ensure the education content has been understood. Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Ryman organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. A fulltime clinical manager oversees the care centre and is supported by a fulltime hospital coordinator. There is at least one RN and first aid trained member of staff on every shift. There are sufficient caregivers on duty to provide care within a safe and timely manner. There is a full time serviced apartment coordinator (enrolled nurse) on day duty with a caregiver on the afternoon shift. The hospital RN oversees the serviced apartments at night. Caregivers interviewed advised that the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. The village manager (non-clinical) and clinical manager/RN work full time and are on call 24/7.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with ministry of health medication requirements. Medication reconciliation is completed by clinical manager/RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior caregivers (in the serviced apartments) who administer medications have been assessed for competency on an annual basis. Registered nurses and caregivers interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly. Hospital emergency stock have expiry dates checked regularly. Standing orders are not used. The service uses an electronic medication system. There were no self-medicating residents.</p> <p>Six hospital and four rest home medication orders were reviewed on the electronic medication system. Two paper-based medication charts (including one respite care resident) were also reviewed. All medication charts reviewed met legislative prescribing requirements.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food and baking is prepared and cooked on-site. The qualified chef is supported by cook and kitchen assistants. All staff have been trained in food safety and chemical safety and complete questionnaires. There is an organisational four weekly seasonal menu that had been designed in consultation with the chef and dietitian at organisational level.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as vegetarian, pureed/soft and gluten free are provided. Two evening options are offered.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. All foods were correctly stored and date labelled. A cleaning schedule is maintained. Feedback on the service is received from daily resident contact, resident meetings, surveys and audits.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Residents interviewed reported their needs were being met. The family members 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 or nurse specialist consultant. Two of six resident care plans reviewed reflected the resident's current needs/supports. Short-term care plans are developed for infections.</p> <p>VCare wound assessments, treatment and evaluations were in place for all wounds including three chronic ulcers, skin tears and five pressure injuries (three facility acquired and two community acquired). Adequate dressing supplies were sighted in the treatment rooms. The wound care champion for the service provides advice and support to RNs and reviews wounds weekly. There is access to the DHB wound nurse as required.</p> <p>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 RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>CI</p>	<p>There is a team of six activities coordinators including two qualified diversional therapists (DT) and four in training who implement the engage programme over seven days. The team attend on-site and organisational in-service relevant to their roles. All activities staff have current first aid certificates.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>meaningful and relevant for the resident group. The service has continued to maintain their continuous improvement rating around activities. There are adequate resources available. Residents receive programmes in their rooms. Daily contact is made with residents who choose not to be involved in the activity programme. Community links include visiting schools, churches, pet therapy, entertainers and visits into the community. The service has a van for outings and hires a mobility taxi for hospital residents in wheelchairs. Regular interdenominational church services are held on site.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Four of five care plans of long-term residents had been evaluated by registered nurses six monthly. One rest home resident had not been at the service six months and one resident was for respite care. Written evaluations describe the resident's progress against the resident's identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 8 March 2017.</p> <p>The facility is well maintained with a refurbishment plan in place. On the day of audit, there were contractors on site repainting some areas and carpets being replaced. All areas were safe and cordoned off.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections, and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (clinical manager) complete a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme (link CI 1.2.3.7). The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There is organisational benchmarking.</p> <p>A confirmed norovirus outbreak August 2015 was well managed and included a debrief meeting with the public health officer to review overall management by staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>A restraint policy is in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. The organisation is aiming to remain restraint free. On the day of audit there were four hospital residents using enablers (two with lap belts, one with bedrails and one with lap belt and bedrail). There were no residents with restraints.</p> <p>Voluntary consent and an assessment process had been completed for enabler. The enabler is linked to the resident's care plan and is reviewed six monthly. The clinical manager is the restraint coordinator. Staff have been provided with restraint and challenging behaviour education.</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Long-term care plans describe the nursing interventions required to meet the residents needs/supports. Two care plans of rest home residents had been updated to reflect the resident's current health status.</p>	<p>1) The care plan of one hospital resident did not record the presence of a pressure injury. Dietitian recommendations had not been updated on the care plan or implemented (link 1.3.3 hospital tracer); 2) blood sugar levels had not been consistently taken as instructed for a rest home resident; 3) weekly weights had not been taken as instructed in long-term care plan for a hospital resident; and 4) the long-term care plan of a hospital resident did not identify previous weight loss and current nutritional status (at risk of malnutrition).</p>	<p>Ensure long-term care plans are updated to reflect the resident's current needs/supports and nursing interventions.</p> <p>60 days</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>Shona McFarlane service has reviewed its 2015 objectives. The 2016 quality objectives include ongoing goals from 2015 (based on clinical data) for example to reduce falls, pressure injuries and urinary tract infections and maintain a restraint free environment. The service identified an ongoing area for improvement through resident meetings and surveys in regards to the food service. The QIP process has been used to plan and evaluate progress towards each objective. Catch phrases have been developed for each objective such as “smells good, tastes good = satisfied residents” and “how low can we go” (falls reduction). Progress towards objectives was seen to have been discussed at the various staff meetings. Two of the 2016 objectives have been evaluated to date and considered to have been met around reduction of falls in the hospital residents and reduction of urinary tract infections. Other objectives remaining will continue through the 2016 year.</p>	<p>The service has maintained its continuous improvement rating with ongoing quality projects. Three projects have been evaluated and evidence the service has achieved the desired results as follows:</p> <p>a) “How low can we go” project was implemented November 2015 and evaluated March 2016. The service implemented strategies to manage falls and reduce rates to four or below falls per 1000 bed nights, in line with Ryman clinical indicator for falls. The action plan included (but not limited to); education of staff, physiotherapy assessments, use of “traffic light system”, mobility guides in bedrooms, analysis of trends, times and location of falls, appointment of lounge carer role, hydration of residents, regular toileting regimes, intentional rounding, sensor mats, wider beds as available and rest areas within the facility. Prior to the project falls peaked at 14 per 1000</p>

			<p>bed nights in the hospital, dropping to 6 per 1000 bed nights in June 2016. The current falls data is within the Ryman clinical indicators. The project is ongoing for the reduction of falls in the rest home.</p> <p>b) The service identified a need to reduce urinary tract infections (UTI). Thirteen UTIs (seven rest home and six hospital residents) were reported in May 2016. Preventative measures were put in place such as adequate hydration and early identification of UTI signs and symptoms. Discussion and informal education occurred at handovers. Disposable wipes were purchased and trialled. Within one month, the UTI rate had dropped to one resident with a UTI in the rest home and one resident with UTI in the hospital. The project will continue to ensure low UTI rates are maintained.</p> <p>c) "Smells good, tastes good, looks good = satisfied residents". This project commenced following success with the "dining with dignity" project in January 2015. The service has maintained continual improvement in food services with the implementation of the following: Management team join the residents monthly for meals to observe; listen and taste food, meals are delivered in hotbox trolley to ensure meals are delivered at an acceptable temperature for residents; chefs rotate serving meals in the dining rooms and review of the feedback book at weekly meetings with management. The 2016 resident survey evidences and increase in resident satisfaction around food services and meals.</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and</p>	<p>CI</p>	<p>Activities are offered in the rest home and hospital wings seven days a week. Residents have a choice of activities to attend in the rest home or hospital lounges. The engage programme has been fully embedded. Residents and relatives interviewed commented positively about the activities provided. There are a number of "village friends"</p>	<p>The Engage programme provides a wide variety of activities both in the rest home and hospital. Activities were observed to be happening simultaneously in the rest home and hospital wings. Residents have the opportunity to attend either session. Residents (interviewed) stated they are involved in the</p>

<p>maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>(volunteers) who are involved in the programme including one-on-one visits to residents.</p>	<p>programme and share ideas for activities, entertainment and outings. They especially enjoy the pet therapy sessions and variety of entertainers. There has been an increase in resident satisfaction around activities as evidenced in the results of the 2016 resident satisfaction survey. Attendance at activities has increased in the hospital from 739 in November 2015 to 1051 April 2016. In the rest home, attendance at activities was 1285 in November 2015 to 1653 in April 2016.</p>
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End of the report.