

# Hilda Ross Retirement Village Limited

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## 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:

<b>Legal entity:</b>	Hilda Ross Retirement Village Limited	
<b>Premises audited:</b>	Hilda Ross Retirement Village	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
<b>Dates of audit:</b>	Start date: 27 October 2016	End date: 28 October 2016
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	148	

# Executive summary of the audit

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## 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
	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

Ryman Hilda Ross provides rest home, hospital and dementia level care for up to 171 residents and on the day of the audit there were 148 residents. The service is managed by a village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

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 and staff.

Two shortfalls from the previous audit around care planning and interventions remain.

There are two areas of continuous improvement awarded for the activities programme and reducing the number of falls.

## 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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, deputy village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## 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 medium or high risk and/or unattained and of low risk.</p>
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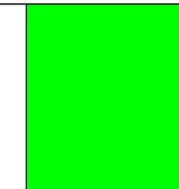
InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review and were informed of any changes in resident health status. The general practitioner completes an admission visit and reviews the residents at least three monthly.

The activity team provide an activities programme which is varied and interesting. The programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups.

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.

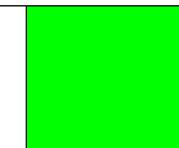
The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in the dementia care unit.

## 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.
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A current building warrant of fitness is posted in a visible location.

## 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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were four residents with restraint and six residents with enablers at the time of audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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, trends identified and acted upon. Benchmarking occurs and a six-monthly comparative summary is completed.

## 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)
<b>Standards</b>	1	14	0	1	1	0	0
<b>Criteria</b>	2	36	0	1	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Interviews with all eight residents (five rest home including one in a serviced apartment, and three hospital) and family confirmed their understanding of the complaints process. Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.</p> <p>Interviews with four managers (village manager, deputy manager, assistant village manager, roaming clinical manager) and twenty staff (five care assistants, seven registered nurses (RNs), one enrolled nurse(EN), five activities coordinators, one physiotherapist, one head chef) confirmed their understanding around the processes implemented for reporting and managing complaints.</p> <p>There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system.</p>
<p>Standard 1.1.9: Communication Service providers</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that are not covered by the agreement. The</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All three family interviewed (one dementia level and two hospital level) stated they were well-informed. Ten incident/accident forms and corresponding residents' files were reviewed and all identified that either the next of kin were contacted or requested not to be contacted (minor events only). Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Interpreter services are available if needed for residents who are unable to speak or understand English. There were no residents with English as their second language.</p>
<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>	<p>FA</p>	<p>Hilda Ross is a Ryman healthcare retirement village located in Hamilton. They are certified to provide rest home, hospital and dementia levels of care for up to 151 residents. In addition, there are 51 serviced apartments with 20 certified to provide rest home level care. Occupancy during the audit was 148 residents (49 rest home, 57 hospital and 39 dementia residents in the care facility, and 3 rest home level residents in the serviced apartments). One resident was on an end of life contract (medical); one resident was dementia level respite and six residents (one rest home and five hospital) were on the DHB patient acute care (PAC) contract.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2016 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been employed by Ryman for 15 years. She has been in her current role since October 2015 and previous to this role was a regional manager for two years. She is an enrolled nurse with a current practising certificate. She has attended over eight hours (year to date) of professional development activities related to managing an aged care facility. The village manager is supported by a regional manager, a deputy manager, an assistant village manager and a clinical manager/RN. At the time of the audit, the clinical manager's role was being filled by a Ryman roaming clinical manager while a suitable replacement was being sought.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>Hilda Ross has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.</p> <p>Family meetings are held six monthly and residents' meetings are held every two months. Minutes are maintained.</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems, policies, and procedures are developed, implemented and regularly reviewed.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two monthly health and safety meetings. A health and safety representative is appointed who has completed health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman Hilda Ross has achieved tertiary level ACC Workplace Safety Management Practice. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place. Lounge carers monitor residents in the lounges. The falls rate for hospital level residents has reduced over the past two years.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of ten incident/accident forms for 2016 identifies that all are fully completed and include follow-up by a registered nurse. The (roaming) clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities. Evidence was</p>

<p>affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>sighted of a Norovirus outbreak in June 2016 with prompt notification to population health, DHB, disability support link (DSL) Waikato, and Ryman Christchurch to inform them of the outbreak.</p>
<p>Standard 1.2.7: 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>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (four care assistants, three registered nurses, one chef, one gardener) provided evidence of signed contracts, job descriptions relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Thirty care assistants work in the dementia unit. Twenty-two have completed their dementia qualification. The remaining eight staff are enrolled and have been employed to work in the dementia unit for less than one year.</p> <p>Registered nurses are supported to maintain their professional competency. Seven of twenty-two RNs have completed their InterRAI training. Staff training records are maintained. There are implemented competencies for RNs, ENs and care assistants related to specialised procedures or treatments including medication competencies and insulin competencies. Two RNs have completed competencies for male catheterisation with sign-off provided by the clinical nurse specialist-continence from the DHB.</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</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. There is a minimum of two RNs and seven care assistants on site at any time. The serviced apartments are staffed with two care assistants on the AM and PM shifts. A coordinator oversees the apartments and the rest home and hospital staff provide cover during the night shift. All staff wear pagers.</p> <p>Activities are provided five days a week for rest home and dementia level residents and seven days a week for hospital level residents. A registered physiotherapist is available nine hours a week and a physiotherapy assistant carries out the rehabilitation programmes developed by the physiotherapist. There are separate laundry and cleaning staff.</p>

<p>providers.</p>		<p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</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>	<p>FA</p>	<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 of monthly blister packs is completed by two RNs and any errors fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency on an annual basis. Care staff 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. All eye drops and creams in medication trolleys were dated on opening.</p> <p>There were no self-medicating residents on the day of audit.</p> <p>Sixteen medication charts (six hospital, six rest home and four dementia care) medication charts were reviewed on the electronic medication system. The effectiveness of 'as required' medications is entered into the electronic medication system.</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 head chef is supported by a weekend cook and kitchen assistants. Staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with the dietitian at an organisational level. Meals are delivered in hot boxes and served from bain-maries in the kitchenettes. Residents have a choice of two meal options for the evening meal.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such gluten free, diary free, diabetic desserts and pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia unit.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the chefs.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>The long-term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. The previous audit identified that not all care plans had all interventions for care requirements documented. This previous audit finding remains. There was documented evidence of resident/family/whānau involvement in the care planning process in the resident files sampled. Residents and relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident.</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 Moderate</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. Care plans are updated to reflect the changes in resident needs/supports (link 1.3.5.2). Short term care plans are developed for infections. There continues to be an improvement required around interventions.</p> <p>Wound assessments, treatment and evaluations were in place for 23 residents with wounds (skin tears, lesions and chronic wounds/ulcers). There were three facility and one DHB acquired pressure injuries on the day of audit (one stage one and three stage two). Adequate dressing supplies were sighted in the treatment rooms. The service has a wound care champion who reviews wounds weekly. The wound care champion and RNs could describe access to the DHB wound nurse or district nurses if required. The GP reviews wounds three monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans.</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>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>CI</p>	<p>The team of activities staff (three with diversional therapy qualifications, one in diversional therapy training and two activities coordinators) coordinate and implement the Engage activities programme across the rest home, hospital and dementia units. Activities staff attend on-site and organisational in-services relevant to their roles. Activities staff hold current first aid certificates.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, themes events and celebrations, indoor bowls, sensory activities, baking in the kitchenettes, outings and drives. A mobility van is hired for hospital residents. Residents in the dementia care unit are taken for daily walks (observed) around the gardens and</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>grounds as weather permits. Rest home residents in the serviced apartments attend the serviced apartment programme or rest home programme. Daily contact is made with residents who choose not to be involved in the activity programme. Community involvement includes entertainers, speakers and church services. The activities staff have been successful in engaging residents in the Engage programme especially around the pampering sessions and men's club as evidenced in the residents' survey results.</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. The service has maintained a continuous improvement rating for activities.</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>Long-term care plans had been evaluated by registered nurses for long term residents who had been at the service for a minimum of six months. One rest home resident was under the PAC funded contract. Written evaluations for long term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, care assistant, activities staff 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>A current building warrant of fitness is posted in a visible location (expiry 8 May 2017).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections 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 (registered nurse) completes a monthly report. Monthly data is reported to</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>The service had an outbreak from June to July 2016 in all areas. Relevant authorities were notified and documentation completed on a daily basis. Staff were kept informed at handovers and by daily memos. Education sessions were increased. All staff received an educational debrief. Public Health acknowledged and congratulated the service on their reactive response to the outbreak. Infection control policy and practice meets best practice.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were four residents with restraint and six using enablers.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</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)
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	The outcomes of InterRAI assessments and risk assessments linked to interventions in care plans reviewed for three rest home residents, one hospital resident and one dementia care resident. Care plans for two hospital and one dementia care resident did not reflect the resident's current health status.	The care plans did not reflect the resident's current level of support for; a) one hospital resident with pain management for a new pain, b) one hospital resident's pressure injury prevention identified as high risk of pressure injury; and c) one resident in dementia care unit with declined mobility (link tracer 1.3.3).	Ensure care plans reflect current interventions and supports required to meet the individual needs.  60 days
Criterion 1.3.6.1	PA	Monitoring forms in place include (but are not limited to); monthly weight, blood pressure and pulse, neurological	i) One dementia resident and one hospital resident with pain did not	i) Ensure pain

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>observations (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 however a shortfall continues as identified around interventions. Residents and relatives confirm their expectations are met and they are kept informed of any changes to health.</p>	<p>have pain assessments completed. Both residents required GP intervention for pain management.</p> <p>ii) One PAC funded resident did not have daily weights recorded as instructed on the discharge plan and GP visit.</p>	<p>assessments are completed for new episodes of pain</p> <p>ii) Ensure monitoring requirements are implemented as instructed from the GP and as documented in discharge summaries.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Systems are in place for the collection, analyses, and evaluation of quality data. Data is collated and analysed. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings. Templates for meetings document actions required, timeframes, and the</p>	<p>Falls were identified in 2015 as an area that required improvement.</p> <p>A plan was developed which included identifying residents at risk of falling, providing falls prevention training for staff, encouraging resident participation in the activities programme, and reviewing of clinical indicator data. Further initiatives implemented included routine checks of all residents specific to each resident’s needs (intentional rounding), the use of sensor mats, perimeter mats, night lights, proactive and early GP involvement, and increased staff awareness of residents who are at risk of falling. Care assistants interviewed were knowledgeable in regards to preventing falls and those residents who were at risk. The plan has been reviewed monthly and discussed at staff meetings.</p> <p>The falls rate for hospital level residents has gradually been reducing over the past two years. The average number of falls for hospital level residents peaked in March 2015 with 18 falls per 1000 bed nights. Since January 2016 falls have steadily declined to as low as 3 falls per month per 1000 bed nights (June 2016).</p>

		status of the actions.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service has focused on implementing the Engage programme and attendance numbers have increased for sensory activities and the men's group. Family/whānau are encouraged to be involved in the Engage activities with their relatives. Monthly activity reviews/reports, monthly attendance statistics and resident meeting minutes' evidence satisfaction with the variety of interesting activities.</p>	<p>The activities team are supported by management to develop new initiatives and resources provided to ensure activities are interesting and enjoyable for residents in all areas.</p> <p>1) The 'sensational senses' part of the Engage programme commenced February 2016 and includes pampering sessions for small groups and one-on-one time. The sensational senses activities were expanded (due to its popularity) in September 2016 to include activities such as making marmalade, muffin in a cup and herbal tea tasting. Over the last four months, hospital attendance at 'sensational senses' has increased with numbers ranging from 20 to 35.</p> <p>2) The fortnightly men's group is a requirement of the Engage programme. The men's group occurs weekly at Hilda Ross in the dementia care unit. Several men from the other areas look forward to attending the men's group which is held in the quiet lounge or one of the dining rooms for larger groups. The dementia care unit activity coordinator (male) relates well to the other men attending the group. He sets themes in the lounge/dining area which is welcoming and reminiscent of times gone by for the men. Themes include a mini bar with the activity coordinator dressed up as the bartender, beer (as desired) and chips and dip. Other themes include snooker, darts (magnetic), cards, gambling den, reminiscing of jobs sports etc., sing-a-long, duck shooting (with nerf bullets), old fashioned barber shop, "tinkering" or "fixing", building or re-vamping items. The events have led to father/son snooker competitions. Families interviewed commented positively and ensure they do not plan outings for their relatives on men's group day. The activity coordinator and dementia care coordinator state that men who tended to wander were able settle and relax for the duration of the men's club and often sessions extend beyond the hour to two hours or more. In August 2015 attendance was 19.2 on average per month and in August 2016 increased to 24.8 per month.</p>

End of the report.