

# Jane Winstone 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:

<b>Legal entity:</b>	Jane Winstone Retirement Village Limited
<b>Premises audited:</b>	Jane Winstone Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 24 October 2014      End date: 24 October 2014
<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>	43

# 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
	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

Jane Winstone provides hospital and rest home level care across 38 beds in the care centre. There are also 20 serviced apartments approved to provide rest home level care. On the day of audit there were four hospital and 39 rest home residents.

The village manager has been in the role since October 2013 and has a health management background. The village manager is supported by a full-time clinical nurse manager who was appointed in June 2014 to support the commencement of hospital services. She is a registered nurse who works full time and is supported by a 24/7 registered nurse team. There is a comprehensive orientation programme and ongoing education plan.

The four shortfalls identified in the previous audit relating to adverse events, allied health instructions, care planning and medications have all been addressed. This audit identified improvements required around documentation of interventions, review of activity plans and care plans at the same time, enabler consent and documentation and aspects of medication prescribing.

## 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.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Policies are implemented to support residents' rights which include ensuring staff communicate with residents and relatives in an appropriate manner that respects the rights of residents. Staff practice open disclosure. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

## 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.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------

Jane Winstone participates in the Ryman accreditation programme, which is overseen by head office. There are facility-specific quality goals established for 2014 and staff are guided by a range of policies and associated procedures. The service has addressed the previous shortfall related to the recording of adverse events. Human resource practices are overseen by head office. There are documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. There is a comprehensive orientation and induction programme in place that provides new staff with relevant information for safe work practices. A training plan for 2014 is in place that includes relevant clinical care. Registered nurses are supported to maintain their professional competency.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------

The Registered nurse is responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records provided evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status. The previous shortfall around the documentation of allied health instructions and interventions to reflect current falls and pressure area risks has been addressed. This audit identifies an improvement around the documentation of interventions to reflect the resident's current needs.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home and hospital residents. Spiritual and cultural preferences and needs are being met.

Education and medicines competencies are completed by all staff responsible for administration of medicines. Medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, allergies and special instructions for administration. The previous audit findings around aspects of medication documentation and photo identification have been addressed. This audit identified an improvement around as required medication indications for use and initially medication chart errors.

Food services and all meals are provided on site. Resident's individual food preferences and dislikes are not known by kitchen staff and those serving the meals. There is dietitian review of the menu. All staff are trained in food safety and hygiene.

## 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. A reactive and preventative planned maintenance schedule is in place. Clinical equipment is calibrated and checked annually. Electrical testing occurs annually.

## 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.		Some standards applicable to this service partially attained and of low risk.
---------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints co-ordinator (registered nurse) with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and ongoing. There are two residents with restraints in use and one resident with an enabler in use. There is an improvement required around enabler consent, and clearly defining restraint or enabler use on resident care plans and associated documents.

## 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.

The infection prevention and control programme is managed by the infection prevention and control officer who is the clinical manager. She is directly responsible to the village manager. The surveillance programme is included in the Ryman accreditation programme, which is reviewed annually. The infection prevention and control committee, which is part of the health and safety committee, meets bimonthly. An individual infection report form is completed for each infection. Thereafter a monthly infection summary is prepared and then discussed at the combined bimonthly Infection Prevention and Control and Health and Safety meeting. A six monthly comparative summary is completed and forwarded to head office. Infection rates are benchmarked against other Ryman facilities. There have been no major outbreaks of infection within the facility since the previous audit.

## 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>	0	14	0	2	1	0	0
<b>Criteria</b>	0	37	0	2	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 complaint management policies exist to guide practice. The service has in place a complaints policy and procedure that aligns with Right 10 of the Code of Health and Disability Consumers' Rights (i.e., the Code). Complaints management is an integral part of the quality and risk management system. The entry pack includes complaints information and complaints forms are also available throughout the facility. The complaints process is also reinforced at resident meetings.</p> <p>A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Complaints are documented on an internal system (VCare).</p> <p>Since the village manager was appointed in Oct 2013 there have been eight complaints received and two of the eight were found to be justified following investigation. Both justified complaints related to standards of care provided. No complaints required reporting to external agencies.</p> <p>The residents meeting and staff meeting minutes include discussions of previous identified opportunities for improvement.</p> <p>Staff receive on-going education on consumer complaints management (last provided 22 May 2014 to 28 staff) and consumers rights (last provided 24 April 2014 to nine</p>

		<p>staff).</p> <p>D13.3h: Information on the complaints process is provided to residents and relatives at entry to the service (confirmed in discussions with six of six residents (i.e., three rest home and three hospital).and two of two relatives (i.e., one rest home and one hospital)). The procedure is also prominent around the facility on noticeboards.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff actively promote effective communication with residents in accordance with Ryman's values and policy (confirmed in discussions with six of six residents (i.e., three rest home and three hospital).and two of two relatives (one rest home and one hospital)). Information is provided on entry and open disclosure is practiced. Management contact relatives and discuss matters in an open manner consistent with the open disclosure policy. The incident/accident forms have a section to indicate if family/whanau have been informed (or not) and the name of the person informed. Staff record contacts with family/whanau on the family/whanau contact record.</p> <p>Incident/accident forms once completed are stored in individual resident records. These identify whether next of kin were notified or not and if not the reason why they were not contacted when the incident occurred. Relatives are notified as soon as staff become aware that a resident's health has changed significantly (confirmed in discussions with two of two relatives (i.e., one rest home and one hospital). Residents are orientated to the service on admission. Informed consent processes are in place. Residents have access to interpreter services which includes access to the Blind Foundation and the Hearing Association.</p> <p>Each resident or their nominated representative is provided with an admission agreement (which is a template document) and a copy is stored onsite in the administration office. The information pack is given on initial visit and is easy to read. The admission agreement is explained by the village manager and if needed the information can be read to residents and is available in large print. In times of emergency when relatives are not available the facility will transport residents to their general practitioner.</p> <p>Staff receive on-going education regarding open disclosure (last provided 23 April 2013).</p> <p>A 13.1 &amp; D 13.2: Each resident or their nominated representative is provided with an admission agreement and a copy is stored onsite in the administration office.</p> <p>A 14.1: The Admission Agreement for permanent residents (sighted) specifies included</p>

		<p>services.</p> <p>D 11.3: The information pack is easy to read and if needed the information can be read to residents and is available in large print.</p> <p>D12.1 &amp; D12.3a: Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term residential care in a rest home or hospital – what you need to know' is provided to residents on entry.</p> <p>D 12.4 &amp; D12.5: Residents (and/or their representatives) are informed in the agreement of their right to apply for a review of their means assessment</p> <p>D16.1b.ii: Residents and family are informed in the Agreement prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b: Relatives are notified as soon as staff become aware that a resident's health has changed significantly (confirmed in discussions with the clinical manager and confirmed in discussions with two of two relatives (i.e., one rest home and one hospital)).</p> <p>D 16.5e, iii: On-call emergency services are available and the costs are met.</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>Jane Winstone provides a total of 39 dual purpose beds in its care centre. There are also 50 serviced apartments on site of which 20 beds are approved to provide rest home level care in the serviced apartments. The care centre is located within a wider retirement village. Ryman Healthcare is governed by a Board of Directors. There is a documented "purpose, values, scope, direction and goals policy". The CEO and senior management work from a head office which is located in Christchurch. Ryman Healthcare's overall mission is defined in the Ryman Healthcare philosophy document. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the Ryman Accreditation Programme (RAP) that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities. Each facility has their own specific RAP objectives and for Jane Winstone in 2014 this includes; a) to ensure full compliance with new and existing staff induction timeframes, b) to raise awareness and the profile of Jane Winstone in the community, c) to improve dining experiences of serviced apartment</p>

		<p>residents, d) to enhance the variety of activities, e) to improve staff morale, f) to ensure successful service delivery to hospital level residents.</p> <p>There are comprehensive policies/procedures to provide rest home care, and hospital-level care (geriatric and medical).</p> <p>The village manager has been in the role since October 2013. She has a health management background. She has completed eight hours of specific management education within the last 12 months, which included her orientation with Ryman and attendance at the annual Ryman manager's conferences.</p> <p>The village manager is supported by a full-time clinical nurse manager who was appointed in June 2014 to support the commencement of hospital services. She is a registered nurse who works full time and is supported by five other registered nurses who work a mix of hours.</p> <p>The management team is supported by the Ryman management team including regional manager who visits the facility once a month on average. The management resource manual includes a number of documented responsibilities of the village manager including a list of reporting requirements. There is a village manager's job description that includes authority, accountability and responsibility including reporting requirements. Ryman Manager's complete a Leadership and Management courses (an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.</p> <p>D17.4 (b) (i): The facility is managed by an appointed manager who has experience in management and the health and personal care of older people and who maintains at least eight hours annually of professional development related to managing a hospital facility.</p> <p>D17.5: A separate clinical manager is appointed to assist the village manager, as the village manager does not hold a registered nursing qualification.</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>	<p>FA</p>	<p>Jane Winstone has a well-established quality and risk management system that is directed by head office and documented in the Ryman Accreditation Programme (RAP) Each facility has its own facility specific plan that links to the overall plan. The RAP includes a schedule across the year for the following areas: RAP head office; general management; staff development; administration; audits/infection control/quality/compliance/health and safety; Triple A/activities. The head office RAP committee provides a monthly RAP programme that aligns with and supports the</p>

		<p>implementation in each service by way of their local RAP committee. The monthly checklist is implemented at Jane Winston at the onsite monthly RAP meetings. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with six of six care assistants (who cover all shifts) and review of meeting minutes demonstrate staff awareness and involvement in quality assurance and improvement activities. The monthly full facility RAP meeting included discussion of 2014 quality goals. Resident meetings are held two monthly and relatives six monthly and minutes are kept. Annual resident and relative surveys are completed. The last resident survey was completed in May 2014. Results are benchmarked against other Ryman facilities. Quality Improvement Plans (QIP's) are completed to address any issues raised. Benchmarking occurs throughout Ryman facilities. Quality improvement plans (QIP) are raised as a result of identified shortfalls. Reporting QIP's to head office ensures monitoring of any service delivery shortfalls. Staff are able to access reports from VCare which demonstrate quality data over time (reports sighted). Staff are proactive around involving residents and relatives in the service. Risk management, hazard control and emergency policies and procedures are in place.</p> <p>D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. There is a document control system in place and any changes or new documents require head office approval and distribution. Obsolete documents are removed. The monthly RAP schedule includes signing off that manuals have been reviewed and documents have been replaced as appropriate. The management resource manual describes the management of policies and procedures and documentation control.</p> <p>D19.2g: Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls and the implementation of the Triple A exercise programme. Sensor mats are in place. Residents are referred to physiotherapists as the need arises.</p> <p>D19.3 There were implemented risk management and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.4 (b): There is a quality improvement plan in place, which is the RAP.</p> <p>D19.4 (d): Performance is monitored and evaluated against the RAP including satisfaction surveying, internal and external quality reviews</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>	<p>FA</p>	<p>All adverse events are recorded in accordance with the accident/incident reporting policy and reported according to policy. Incidents and accidents are documented by staff when they occur. Once the form has been processed and the data entered into VCare the original completed form is filed in each resident's clinical record. Staff document all incidents and accidents and these are processed by management and results are reported. This is an improvement from the previous certification audit when discrepancies were evidenced. Incident /accident forms sighted in residents' clinical records were fully completed and follow-up was documented.</p> <p>Staff receive feedback through meetings. Improvements are made to the service as and where appropriate. QIP's are developed to implement improvements. Adverse events are linked to the organisation's benchmarking programme and the data are used for comparative purposes. Minutes of the monthly RAP (full facility) committee meetings, two monthly health and safety meetings and weekly management meetings reflect a discussion of incidents and accidents and any actions taken. Six monthly comparative reviews identify further facility improvements required.</p> <p>There is an open disclosure policy that identifies the communication responsibilities to inform family/relatives of the event and actions taken. Incident/accident forms have a section to indicate if next of kin have been informed (or not) of the event. Discussion with two of two family members informed communication is good and that they are informed of any change in health status of their family member.</p> <p>Staff receive on-going education regarding the reporting of incidents, accidents and hazard management (last provided 21 August 2014 to 28 staff).</p> <p>Staff can describe the incident reporting process and their role (confirmed in discussions with six of six care assistants, two of two registered nurses and the clinical manager).</p> <p>D19.3b: There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing.</p> <p>D19.3c: Management is aware of their reporting obligations to report serious adverse events to the relevant agencies (confirmed in discussion with the village manager).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>Human resource policy and practices are overseen by head office staff and senior management. A review of five of five staff employment records (i.e., the clinical</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>manager, two registered nurses and two care assistants) showed that employment records were consistent with Ryman policy. There are documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Additional role descriptions are in place (eg, for the infection prevention and control coordinator and the restraint coordinator).</p> <p>The village manager ensures that all health practitioners providing services to residents hold current professional qualifications. Qualifications are validated on appointment, including health practitioner registrations and relevant scopes of practice. A register of registered health practitioners practising certificates is maintained within the facility (sighted). This includes the registered nurses, the current general practitioners' registration and the pharmacist. The podiatrists practising certificates are held in their contract records.</p> <p>The village manager oversees the recruitment process in consultation with the clinical manager. This process operates in accordance with Ryman policies.</p> <p>All newly appointed staff receive a comprehensive orientation/induction programme that provides them with relevant information for their role. The programme is tailored specifically to each position such as (but not limited to) care assistants, senior care assistants, registered nurse, and clinical manager. The orientation/induction training for care assistants, on completion, is equivalent to foundation level two NZQA. There is a specific employees' induction manual. Written questionnaires are completed for specific areas (e.g., culture, complaints, advocacy and informed consent). Following orientation and induction care assistants are encouraged to enrol in the ACE programme to achieve ACE core, and ACE advanced, as appropriate, if not achieved prior to employment. The facility employs an ACE and inductions officer for eight hours a week to oversee the care assistant training programme. Currently all except two care assistants (i.e.: 14 of 16 care assistants) have completed or are in the process of completing ACE Foundation level and eight of the 16 hold ACE Advanced qualifications. The registered nurses are supported to maintain their professional competency by discussing training needs at annual appraisals and through the two monthly journal club. There are clinical educators employed by head office who provide clinical support at facility level.</p> <p>Staff training records are maintained. Training needs for staff are identified and discussed during the annual performance appraisal process.</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>	<p>FA</p>	<p>The facility is staffed according to policy with flexibility to match resident acuity. The policy identifies the rationale for determining staffing levels and skill mix for safe service delivery.</p> <p>D17.4a-d: Currently the facility is staffed by registered nurses 24 hours a day, seven days a week. The team of registered nurses are supported by the clinical manager who is employed full-time and is a registered nurse with a current practising certificate. She is actively involved in care management. Both the village manager (non-clinical) and/or the clinical manager are typically on site during the working week. The clinical manager typically works Sundays to Thursdays. The village manager typically works Monday to Friday. There are at least two care staff on duty 24 hours a day, seven days a week.</p> <p>The serviced apartments are staffed by a senior caregiver from 8 am to 4.30 pm each day plus two other caregivers (one works 7-3 and the other works 7.30 to 11am daily). There are two caregivers in the serviced apartments in the afternoon (one 4.30 to 9pm and the other 5pm to 7pm). The care centre oversees the apartments after 9pm.</p> <p>The service has a number of general practitioners currently and there are plans to formally contract one of the GPs in the near future to provide a more comprehensive service.</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>PA Moderate</p>	<p>The service uses individualised medication blister packs for regular and PRN medications. Medication reconciliation is completed on delivery of medications and the signing sheet is signed by the RN checking the medications. Any discrepancies are fed back to the pharmacy. The two medication trolleys are kept in one locked medication room. Registered nurses and senior caregivers are competency assessed annually and responsible for administering medication. Medication education was completed in August 2014. RN's have not completed syringe driver training to date. Hospice provided palliative care support. Controlled drugs are stored in a controlled drug safe in medication room. There are weekly controlled drug checks. Standing orders are in use. There are three residents self-medicating who have been competency assessed. Medications are stored securely in their rooms. The resident self-medicating assessments are reviewed three monthly by the GP and RN. Self-medication is monitored by the RN on duty. All eye drops and ointments are dated on opening. Medication fridge temperatures are monitored weekly. Administration signing sheets reviewed are correct and complete. Two medication competent persons sign for the administration of controlled drugs. PRN medications administered have a date and time of administration recorded. PRN medication expiry dates are checked monthly.</p>

		<p>Emergency oxygen and suction is checked weekly. Blood sugar monitoring and pain monitoring charts are kept in the medication folder.</p> <p>Individually prescribed resident medication charts are in use and this provides a record of medication administration information with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible, signed and dated. There is an improvement required around the prescribing of PRN medications and prescribing errors.</p> <p>D16.5.e.i.2; All 10 medication charts reviewed charts have photo identification and an allergy status documented on the medication chart. Ten medication charts reviewed (eight rest home and two hospital) identified that the GP had seen the resident 3 monthly and the medication chart was signed.</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>There is a cook and morning kitchen hand on duty each day. There is an evening kitchen hand to heat and serve the semi-prepared tea. The four weekly seasonal menu is designed and reviewed by a registered dietitian (March 2014) at an organisational level. The cook has on-line and email communication with the Hotel Services Manager at head office. All meals and morning teas are cooked on site. The hot meal is at midday with a lighter tea. The cook receives resident dietary information and needs from the RN and is notified of any changes to dietary requirements (vegetarian, moulded foods) or any resident with weight loss. The cook (interviewed) is able to describe high calorie foods offered for weight loss. Likes, dislikes and special diets are known. Alternative meals are offered for those residents with dislikes or religious preferences. Alternative meats are offered for pork and chicken meals. Menus are displayed. Meals are delivered in a bain mairre to the dining room. Meals to rooms are plated and covered with heat lids. Lip plates, sipper cups and special utensils are available for residents to promote independence with meals.</p> <p>The service has a workable kitchen with a separate area for dishwashing, food preparation and cooking. The fridges and freezers temperature are recorded weekly. The dry goods area is tidy with all goods off the floor and dated. All foods in fridges are dated. End cooked temperatures on all meals are checked and recorded weekly. Staff are observed wearing correct personal protective clothing. Chemicals are stored in a locked cupboard within the kitchen. Cleaning schedules are maintained.</p> <p>Six residents interviewed (three rest home and three hospital) are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys. The cook</p>

		<p>(interviewed) interacts with the residents during meal times (observed). There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal hygiene, and special diets.</p> <p>D19.2: Food services staff have completed food safety and hygiene courses and chemical safety August 2014.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The outcomes of six monthly written evaluations and review of risk assessments in three of four long term resident files (one hospital and two rest home) are reflected in the long term care plans. One rest home resident has not been at the service six months. The previous finding at the partial provisional audit has been addressed.</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>	PA Low	<p>Five resident files were reviewed (three rest home, one respite care – rest home, and one hospital). Assessment tools completed on admission include a) Waterlow pressure area risk assessment, b) three day continence diary, c) mobility assessment d) coombes falls risk e) mini nutritional assessment as applicable f) pain assessment g) wound assessment h) behaviour assessment and j) restraint/enabler assessment. Risk assessments are reviewed when there is a change to condition or at least six monthly. There is an improvement required around documentation of interventions to reflect the resident's current health status.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessment and treatment plan and evaluations are in place for five skin tears, two lacerations, one surgical wound, three minor wounds and four residents with leg ulcers. Photos have been taken and there is evidence of wound nurse specialist input into wound care management.</p> <p>There are two residents with pressure areas (grade 2). Pressure area prevention strategies are included in the long term care plan. There is an improvement required around short term care plans. GPs are notified of all wounds and non-healing skin tears. Wound nurse specialist advice is readily available as required. Wounds, skin integrity and pressure areas in service were provided in September 2014.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and two RN's interviewed. Continence</p>

		<p>management education was provided in August 2014.</p> <p>Calibrated weighing chair scales are used to weigh residents monthly. Weight loss short term care plans are in use as evidenced which include drink supplements, food and fluid monitoring, frequency of weighing, GP/Dietitian notification. The resident dietary requirement is reviewed and a copy sent to the kitchen. A dietitian is available as required and notified for any weight loss of 2kg or more per month. Food and fluid monitoring charts are evidenced in use.</p> <p>Short term care plans are available for use to document interventions for short term needs/changes to health. Relatives interviewed state they are kept informed of any changes to the residents' health.</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 needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are two full-time activity co-ordinators and one part-time and one reliever that provide a separate Monday to Friday activity programme for the rest home/ hospital and serviced apartments. A company diversional therapist (DT) oversees the activity programmes. The activity co-ordinators attend Ryman workshops and on-site in-services. All hold a current first aid certificate. Two of the activity team have commenced training towards DT qualifications.</p> <p>The programme is planned monthly and includes Ryman minimum requirements for the "Engage" programme. Activities programmes are displayed on notice boards around the facility. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme that was designed by the Ryman group and includes exercises for less active residents and a more active exercise programme for mobile residents and serviced apartments. One of the activity co-ordinators has attended Triple A instructor training. Other activities such as; crafts, happy hours, movies, board games, word games, walks and open discussions are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One on one time is such as sensory or reminiscing activities are spent with residents who are unable to actively participate in the activities. Residents in serviced apartments can choose to attend the serviced apartment or rest home/hospital activities.</p> <p>Entertainers are scheduled weekly. Community visitors include guest speakers (diabetes nurse, museum speaker, and neurological society), school children, canine pet therapy and returned service association member, old time dancers and church visitors. Open church services are held weekly and residents are supported to attend their own churches. There are regular outings, scenic drives, cafes, shopping and library visits. There is an activity goal to hire a mobility van to ensure hospital residents</p>

		<p>who wish to go on outings have suitable transport provided.</p> <p>The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies etc. are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that includes an activities assessment and 'your life experiences'. The activity plan includes headings for comfort and wellbeing, outings, interests and family and community. A resident attendance list is maintained for activities, entertainment and outings. Resident meetings are held two monthly and family meetings six monthly. There is an opportunity to provide feedback on activities at the meetings and six monthly reviews. Resident and relative surveys also provide feedback on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan. Three of five resident files sampled (one rest home, one hospital) contained written evaluations completed six monthly. One rest home resident is on respite care and another rest home resident has not been at the service six months. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems.</p> <p>D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.</p> <p>D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.</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>	FA	<p>The building holds a current warrant of fitness which expires on 17 March 2015. The service employs a full-time maintenance officer for the facility. Preventative and planned maintenance is carried out. Contractors are called in as required and there are 24/7 contractors available for essential services. Building maintenance is carried out when necessary and records maintained. Water temperatures are monitored. Medical equipment including hoists and chair scales are checked and/or calibrated annually next due July 2015. Annual electrical testing and tagging has been completed June 2014. The maintenance officer is a trained electrical tester.</p> <p>The staff interviewed state they have adequate equipment to safely deliver cares including; lifting and standing hoists, sensor mats, electric beds, wheelchairs, pressure</p>

		area mattresses and cushions, mobility aids and chair scales.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy states the routine/planned surveillance programme is organised and promoted via the Ryman accreditation programme calendar. The health and safety committee meet bimonthly and also act as the infection prevention and control (IPC) committee. Effective monitoring is the responsibility of the infection prevention and control officer who is the clinical manager. She is directly responsible to the village manager who in turn is responsible to the regional manager. An individual infection report form is completed for all each infection. Data is logged into VCare, which gives a monthly infection summary. This summary is then discussed at the bimonthly combined health and safety and infection prevention and control meetings. Three month and six monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Jane Winstone include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing audit (last conducted April 2014-100%), housekeeping (March 2014-100%), linen services (March 2014-100%) kitchen hygiene (January 2014-100%). Infection rates are benchmarked across the organisation. The majority of infections at Jean Winstone in the 12 months from 1 October 2013 were urinary tract infections (ie, 57%). There have been no outbreaks of infection within the facility since the previous audit. Staff receive ongoing education regarding infection prevention and control (last provided 18 September 2014 to 31 staff) and outbreak management (last provided 24 June 2014).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Low	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service had been restraint free up until July 2014. There are two restraints (bedrails) and one enabler in use for three hospital residents. There is an improvement required around consent for enablers. The restraint co-ordinator (RN) maintains a monthly restraint and enabler register is maintained.</p> <p>The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation. There is restraint monitoring guidelines in place. Risks known to be associated with the use of restraints/enablers</p>

		<p>(three files reviewed) are reflected in the care plan. There is an improvement around the identification of restraint or enabler in use.</p> <p>Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval and review process. Types of restraint have been approved for use by the restraints committee that meet six monthly.</p> <p>Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education was provided in April 2014 by the clinical educator.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Individually prescribed resident medication charts are in use and this provides a record of medication administration information with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is legible, signed and dated.</p>	<p>a) There are no indications for use on three out of 10 medication charts reviewed for oxzepam, domperidone and oxynorm. b) Prescription errors (two) and signing errors (two) that have been crossed out do not have a date or signature.</p>	<p>a) Ensure all prn medications have an indication for use prescribed. b) Ensure all errors are crossed with a single line, dated and signed.</p> <p>60 days</p>
<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>	<p>PA Low</p>	<p>Five resident files were reviewed (three rest home, one respite care – rest home, and one hospital). Residents interviewed (three rest home, three hospital) report their needs are being appropriately met. Relatives interviewed (one rest home, one hospital) state the needs of their relatives are being</p>	<p>(i) There is no short term care plan in place for the management of a sacral pressure area for a hospital resident. (ii) There is no documentation in the care plan for a resident with risk of</p>	<p>Ensure interventions are documented in the care plans to reflect the residents current needs.</p>

		appropriately met and they are kept informed of any changes to health and interventions required. Risk assessments are reviewed when there is a change to condition or at least six monthly. There are examples of short term care plans in use to document interventions for short term needs/changes to health. However further improvements are required in this area.	choking as identified in progress notes.	90 days
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service had been restraint free up until July 2014. There are two restraints (bedrails) and one enabler in use for three hospital residents. The restraint co-ordinator (RN) maintains a monthly restraint and enabler register is maintained. The long term care plan (under safety/risk) includes the use of restraint/enablers, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. Risks known to be associated with the use of restraints/enablers (three files reviewed) are reflected in the care plan.	The care plans of the three residents (two with restraint, one enabler) does not clearly identify if enabler or restraint is in place.	<p>a) Ensure the resident is able to voluntarily choose and sign for enabler use. b) Ensure the care plan clearly identifies enabler or restraint use.</p> <p>90 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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

End of the report.