

Yvette Williams Retirement Village Limited

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Yvette Williams Retirement Village Limited
Premises audited:	Yvette Williams Retirement Village
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 December 2014 End date: 9 December 2014
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	81

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Yvette Williams Retirement Village is a Ryman Healthcare facility, situated in Dunedin. The Yvette Williams facility is modern, spacious and extends across three levels. The facility provides rest home, hospital and psychogeriatric level care. On the day of audit, there were three rest home residents and 53 hospital residents in the second floor rest home/hospital unit and 21 residents in the psychogeriatric unit. There were four rest home residents residing in serviced apartments.

The village manager is qualified and experienced in business and financial management and is supported by a clinical manager (registered nurse) who oversees the care centre. There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. The service has been actively working on reducing the incidence of falls, reducing turnover of staff and improving communication with service users. Feedback from residents and families was very positive about the care and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There are two areas of continuous improvement awarded around implementation of quality improvement plans and the activities programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

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

Organisational management

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.

Yvette Williams has implemented the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team.

Yvette Williams provides clinical indicator data for the three services being provided (hospital, rest home and psychogeriatric). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

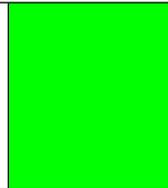
Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whanau interviewed confirm they are involved in the care plan process and review. Short term care plans are in use for changes in health status. Interventions are documented to reflect the resident's current needs. The activity coordinators provides an activities programme in each unit that meets the abilities and recreational needs of the residents that is varied, interesting and involves the families and community. There are 24 hour activity plans for residents in the special care unit that is individualised for their needs. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Medication is appropriately stored, managed, administered and documented. Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

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.

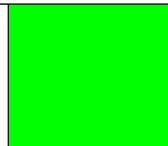


Standards applicable to this service fully attained.

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

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.

There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and ongoing. There are 10 hospital residents with restraints in use and one hospital resident with an enabler.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented and align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents have been provided with information on admission which includes the Code. Staff have been provided with training around resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with 10 caregivers (one rest home/serviced apartments, five hospital, and four psychogeriatric) demonstrate an understanding of the Code. Resident rights/advocacy training was provided in April 2014. Residents interviewed (two rest home from the serviced apartments and five hospital) and relatives (four hospital and two psychogeriatric special care unit) confirm staff respect privacy, and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make</p>	FA	<p>The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Consent is obtained as part of the</p>

<p>informed choices and give informed consent.</p>		<p>resident admission agreement for release of health information, and release of information to family or representative. Separate consent is obtained for photographing for promotional displays, and care choice/procedures.</p> <p>Resuscitation orders are appropriately signed.</p> <p>D3.1.d: Discussion with family members identifies that the service actively involves them in decisions that affect their relative's lives. Advanced directives are completed for residents who are competent to make the decision.</p> <p>D13.1: Eight admission agreements are sighted and signed. The admission process and documentation includes the admission agreement, and a resident acknowledgement form. Each resident is offered a choice of a standard or premium room and is informed of the extra charge for premium rooms. If a standard room is available at another facility within a 10 km radius but the resident or representative chooses to stay at Ryman Yvette Williams, then the premium charge applies. If a standard room is not available at another facility within the 10km radius of Ryman Yvette Williams then the extra premium fee is not charged. Prospective residents are informed of this arrangement prior to signing the admission agreement.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the village manager, and the clinical manager confirm practice is consistent with policy. Residents interviewed confirm that they are aware of their right to access advocacy.</p> <p>D4.1d; Discussions with relatives confirm that the service provides opportunities for the family/EPOA to be involved in decisions</p> <p>ARC D4.1e, ARHSS D4.1f: The resident file includes information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau</p>	<p>FA</p>	<p>D3.1h: Residents and relatives interviewed confirmed that family and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during</p>

<p>and their community.</p>		<p>the audit.</p> <p>The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with residents confirm the activity staff help them access the community such as outings.</p> <p>D3.1.e Discussion with caregivers, activities coordinators, residents and relatives confirm that residents are supported and encouraged to remain involved in the community and external groups.</p>
<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 complaints policy and supporting documents that is being implemented. The village manager has the overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A feedback form has been completed for each complaint recorded on the complaint register. The number of complaints received each month is reported to staff via the various meetings. A complaints register has been maintained that includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Verbal complaints are included and actions and response are documented. Discussion with residents and relatives confirm they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility. There have been 11 recorded complaints during 2014 which were reviewed. All had been investigated with updates and resolution provided to complainants. All complaints were closed at the time of audit. A quality improvement plan is developed for individual complaints if this is warranted.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry including the special care unit information booklet.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family members are provided with a welcome pack which includes information about the Code. They are also provided with an opportunity to discuss information prior to admission. Information is also given to next of kin or enduring power of attorney (EPOA) to read and</p>

		<p>discuss with the resident in private. Large print posters of the Code and advocacy information are displayed through the facility. The bimonthly resident meetings also provide an opportunity for residents and relatives to raise issues/concerns (minutes sighted). Residents and relatives interviewed advised that information has been provided around the Code. The village manager and senior clinical staff have an open door policy for concerns or complaints.</p> <p>D6.2 and D16.1b.iii the information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet, advocacy and Health & Disability Commission. The village manager and clinical manager described discussing the information pack with residents/relatives on admission.</p> <p>ARHSS D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Ryman has policies that support resident confidentiality, privacy, collection and storage of information, and access to health information (disclosure). During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Resident files are stored out of sight. Staff could describe definitions around abuse and neglect that align with the Ryman policy. Relatives interviewed stated that the care provided was very good. Interviews with residents confirm their values and beliefs were considered. Prevention and detection of abuse training was last delivered in June 2014.</p> <p>D3.1b, d, f, i the service has a philosophy that promotes quality of life, involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Caregivers interviewed could describe how choice is incorporated into resident cares. Interview with residents confirms that staff are respectful.</p> <p>D4.1a Nine resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan. This includes</p>

		<p>cultural, religious, social and ethnic needs.</p> <p>D14.4 there are instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.</p> <p>ARHSS D4.1b Three psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A3.2 Ryman has a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit the staff report there are no residents that identify as Maori.</p> <p>D20.1i The Ryman Maori health policy guides staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out, where the resident and/or whanau as appropriate/able are invited to be involved. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</p> <p>D3.1g The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whanau.</p> <p>D4.1c Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p> <p>ARHSS D4.1d: Three psychogeriatric care plans reviewed included the</p>

		resident's social, spiritual, cultural and recreational needs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Ryman Accreditation Programme (RAP) full facility (including all staff) meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager and nine registered nurses confirm an awareness of professional boundaries. Caregivers, enrolled nurses, and registered nurses were able to discuss professional boundaries in respect of gifts.</p> <p>ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two caregivers from the psychogeriatric unit could describe how they build a supportive relationship with each resident. Interviews with three families from the psychogeriatric unit confirmed the staff assist to relieve anxiety.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Ryman Healthcare has a Ryman Accreditation Programme (RAP) that includes an annual planning and a suite of policies/procedures to provide rest home care, hospital care and specialist psychogeriatric care. Policies are reviewed at an organisational level and input is invited from facility staff. All Ryman facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies.</p> <p>Clinical indicator data is collected against each service level and reported through to head office for monitoring. Indicators include (but not limited to): falls, medication errors, infection. Feedback is provided to staff via the various meetings that are determined as part of the RAP. Quality Improvement Plans (QIP) are developed where thresholds exceed expectation, for example: QIP for in-service attendance, Vcare kiosk roll out</p>

		<p>and laundry labelling projects were sighted. QIP's are also developed opportunistically, and all reviewed are seen to be resolved and closed out (also refer evidence against continuous improvement 1.2.3). Vcare is the electronic system used by all sites to report relevant information through to head office, and is seen to be used at Yvette Williams.</p> <p>ARC A2.2 Services are provided at Yvette Williams that adhere to the health & disability services standards. There is a quality improvement programme that is being implemented that includes performance monitoring. ARC D1.3 all approved service standards are adhered to.</p> <p>There are human resources policies/procedures to guide practice, and an annual in-service education programme that is incorporated into the RAP. There is evidence at Yvette Williams that the in-service programme is being implemented. There is evidence of opportunistic education being provided at handovers.</p> <p>ARC D17.7c There are implemented competencies for caregivers and registered nurses. Core competency assessments and induction programmes are being implemented. Competencies are completed for key nursing skills including (but not limited to); a) moving & handling, b) insulin, c) sub cut fluids and d) medication. RNs have access to external training.</p> <p>Residents interviewed and relatives were positive about the care they receive.</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>There is an incident reporting policy, and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. A sample of incident forms reviewed October 2014 identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters is available.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>D16.4b relatives stated that they are informed when their family members</p>

		<p>health status changes.</p> <p>D11.3 The information pack is available in large print and this can be read to residents.</p> <p>ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A specific introduction to the special care unit booklet provides information for family, friends and visitors visiting the facility.</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>Yvette Williams provides care within a three level facility. On the days of audit there were seven rest home residents (four in serviced apartments and three in the hospital care centre), 53 hospital level residents in the 60 bed care centre and 21 psychogeriatric residents in the special care unit. There are 32 serviced apartments on the third level which have all been certified as suitable for rest home level care. All levels are accessible by a lift or two stair wells. The basement is used for car parking and storage.</p> <p>There is a documented ' purpose, values, scope, direction & goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the RAP that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities. Ryman Healthcare have operations team objectives 2014 that include a number of interventions/actions for; a) quality system focus forward, b) national dementia project, c) human resources - recruitment/induction processes, d) health and safety, e) InterRAI project, and f) clinical education. Each service also has their own specific RAP objectives. The 2014 objectives for Yvette Williams are grouped under the following headings: resident and relative satisfaction, clinical, human resources and health and safety. Each main objective identifies the goal – e.g. Improve care satisfaction. Each goal then outlines the action to be taken to achieve the goal – e.g. call bell response time is within acceptable limits. Progress towards objectives is updated as part of the RAP schedule, with the reviews of the facility objectives having been conducted in April and August. Final</p>

		<p>review is due this month</p> <p>The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and psychogeriatric care. There is a medical component to the certificate. There is a contracted physiotherapist that provides services for 16 hours per week and a physiotherapist assistant that works 25 hours per week. There are two general practitioners who are contracted to provide medical services.</p> <p>The village manager at Yvette Williams is non clinical and has been in the post for 18 months. The village manager has a background in commerce and management in both health and non-health services. The village manager has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. She is supported by a clinical manager (RN) who oversees clinical care at the care centre. The clinical manager has been employed with Ryman for the past 24 having previously worked as a caregiver prior to completing her registered nurse training. She has been the clinical manager for the past two years. The management team is supported by the Ryman management team including a regional manager who was present on the days of audit.</p> <p>The management resource manual includes a number of documented responsibilities of the manager including a list of reporting requirements. There is a manager's job description that includes authority, accountability and responsibility including reporting requirements. The Ryman managers complete a Leadership and Management course (an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. During a temporary absence, the clinical manager will cover the manager's role with support from the regional manager. The regional manager provides oversight and support.</p> <p>D19.1a; a review of the documentation, policies and procedures and from discussion with staff, identified the service operational management strategies, QI programme which includes culturally appropriate care, to</p>

		minimise risk of unwanted events and enhance quality
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Yvette Williams has implemented the Ryman RAP system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP committee, full facility, registered nurse and caregivers. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.</p> <p>The service has policies and procedures and the RAP programme defines systems to provide an assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow implementation by staff. A number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence/knowledge and education packages which are based on their policies.</p> <p>Key components of the quality management system link to the RAP committee at Yvette Williams who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports to that are sent to head office (Christchurch) provide a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical manager collected across rest home, psychogeriatric and hospital services as well as staff incidents/accidents. The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. The Yvette Williams health and safety and infection control committees meet bimonthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation.</p> <p>Yvette Williams is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. Weekly reporting to the regional manager</p>

		<p>includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix. QIP's reviewed are seen to have been closed out once resolved.</p> <p>D19.3: There is a comprehensive H&S and risk management programme in place. There are policies to guide practice. Yvette Williams has an H&S representative (interviewed) who has completed training.</p> <p>D19.2g fall prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Ryman (including Yvette Williams) has recently introduced a fluid assistant/lounge caregiver position. This was introduced for two reasons: a) in response to relative feedback that indicated residents were unsupervised in lounge areas and b) in an attempt to reduce clinical indicator rates (eg: falls).</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>D19.3c: The service collects incident and accident data. A sample of incident forms for October 2014 were selected for residents. All forms reviewed had been completed appropriately including investigation and preventative actions. All had been reviewed by the clinical manager. Seven resident files were traced and all reported incidents had an accompanying incident form and the incident documented in progress notes.</p> <p>D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark for example skin tears and falls. Corrective action plans were completed and signed off.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications</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</p>	<p>FA</p>	<p>The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Relevant documentation was seen in 12 staff files reviewed.</p>

<p>requirements of legislation.</p>	<p>Additional role descriptions are in place for infection control coordinator, restraint coordinator, in-service educator, and health and safety officer, fire officer. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained. Interview with the management team (regional manager, village manager, clinical manager and two unit managers) inform a more stable workforce with a reduction in staff turnover identified as one of the facility's objectives for the current year. The management team attributes this to improve communication and fostering a culture change over the past two years. Interview with caregivers and registered nurses inform management are supportive and responsive.</p> <p>There is a 2014 training plan developed for Yvette Williams that is aligned with the RAP. There is a registered nurse who oversees staff induction and the ACE programme, and one who facilitates the in-service calendar. Participation in the ACE programme is a requirement for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly at all Ryman facilities and subjects covered include (but not limited to) nutrition and weight loss, and communication. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on. Ryman has a 'Duty Leadership' training initiative that all RNs, ENs and Senior Leaders complete. It includes four modules/assignments around resident rights, customer service, leading colleagues and key operations/situations.</p> <p>The clinical structure in the facility includes a clinical manager, registered nurse coordinators in the hospital and psychogeriatric units and a team of registered nurses and care staff. The serviced apartments (where there is currently four rest home level residents) have a coordinator (enrolled nurse). The coordinator from the hospital unit (registered nurse) oversees the care planning/delivery process for the rest home level residents in the apartments.</p> <p>There are currently 25 caregivers employed in the special care unit. Twenty two have completed dementia standards. Of the three who have not completed the unit standards, two have started and one is yet to start. All three commenced employment in the past six months.</p> <p>Ryman provide a comprehensive induction programme at Foundations Level</p>
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		<p>2 compliance and qualification to all care staff and actively support the Health Ed Trust ACE Programmes and provide incentives to their staff to undertake both the general and dementia modules. Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Caregiver's advise that RN's (including coordinators) are supportive and approachable. Staff advise that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm there are times when the facility appears to be short staffed, this was not observed during the audit. Staff and management inform there is capacity to increase staff numbers based on resident acuity, and there is access to both casual staff and part-time staff to cover unexpected absence.</p> <p>All hospital unit rooms have been previously been assessed as 'dual purpose', and all serviced apartments are assessed as suitable for rest home level care. The serviced apartments are currently managed by an enrolled nurse with oversight from the coordinator based in the hospital unit. Caregivers work during the morning and afternoon shift. There is currently not a designated caregiver on duty overnight in the serviced apartment area (level three of the building), however, call bells are linked to staff pagers. Staff respond to call bells and conduct at least two checks on residents during the night.</p> <p>There is a registered nurse on duty at all times – one in the hospital area and one in the special care unit. There are at least two RN's on duty in the hospital unit during the day. The caregivers cover a mix of long and short shifts. There are designated cleaners, laundry staff, activities staff, gardeners, and administration staff. The clinical manager works 40 hours per week and oversees the clinical care of all residents. The village manager also works 40 hours per week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>The resident files are appropriate to the service type. Residents entering</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard in each area. Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p> <p>D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has a well-developed assessment process and resident's needs are assessed prior to entry. The information booklet answers a number of questions around admission and entry processes. The clinical manager and respective unit coordinators screens potential clients for entry to services and requests confirmation of level of care to be received the day prior to admission. Consultation occurs with clinical personnel regarding placement and specific clinical needs. Information gathered at admission is retained in resident's records.</p> <p>Eight residents and seven relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the clinical manager or village manager.</p> <p>D13.3 the admission agreement reviewed aligns with a) -k) of the ARC contract. Nine admission agreements sighted had been signed.</p> <p>D14.1 Exclusions from the service are included in the admission agreement.</p> <p>D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>Three resident files reviewed included a needs assessment as requiring hospital level dementia care.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Transfer information is completed by the registered nurse or clinical manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. The transfer of residents or admission to other provider's policy includes instructions for documentation and whom to notify. Relatives interviewed confirmed they are well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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>The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. The service uses individualised medication blister packs for regular medications and as required medications. Medication packs are checked against the medication chart on delivery by a registered nurse and this is recorded. Three medication rooms were viewed (rest home, hospital and special care unit) and one medication cupboard (serviced apartments). All medications rooms are secure. Medications trolleys are locked (one in the rest home, two in the hospital and one in the dementia care unit). Contents are all within expiry dates and eye drops are dated on opening. Expiry dates of all medications are checked monthly. There is a specimen signature list of all medication competent persons. Caregivers, EN or registered nurses administer medications in the serviced apartments, rest home and special care unit. RN's and EN's administer medication in the hospital unit. Staff attended medication administration training and have completed medication and insulin competencies. RNs have completed syringe driver training. There is one self-medicating resident in the hospital (inhalers only) with a current competency and assessment completed. Reviews are conducted three monthly. These are stored securely in the resident's room. There are current standing orders. Medication administration is observed to be compliant in all units during the audit. Rest home residents residing in the serviced apartments are administered medications from medication competent caregivers and/or enrolled nurses.</p> <p>Medications to be returned to the pharmacy are stored securely until collected by the pharmacy. Medication fridge's are monitored weekly</p>

		<p>(records sighted). Oxygen, suction and emergency trolley in the hospital unit is checked and signed off (as sighted). There were no gaps identified on the 18 medication signing sheets reviewed.</p> <p>D16.5.e.i 2; 18 Medication charts reviewed identified three monthly medication reviews signed by the attending GP.</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 company hotel services manager. The service employs a qualified cook Monday to Friday and the weekends. The cook is supported by a kitchen assistant and a morning and afternoon kitchen hand each day. There is a four weekly seasonal menu that has been designed and reviewed by a dietitian at organisational level. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly review and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are written up on the kitchen whiteboard. Normal, mouli, vegetarian, diabetic diets and gluten free diets are provided. Food is delivered in hot boxes to the kitchenettes and dining areas in each area and served from Bain Marie. Caregivers serve the meals and have a resident like/dislike list in each dining area. The cook plates and labels special diets. Nutritious snacks such as desserts, yoghurt, custard, biscuits and sandwiches are available over 24 hours for residents in the dementia unit. Staff are observed sitting with the resident when assisting them with meals.</p> <p>The service has a large workable kitchen with a separate dishwashing area, baking, cooking and storage areas, a walk-in chiller, freezers and freezers, walk-in pantry, two combi ovens and an electric oven. All foods are date labelled in the freezers and fridges. Dry goods in the pantry are sealed and date labelled. There is a three monthly clean of the large dry goods bins. Fridge and freezer temperatures are recorded daily and there is evidence of corrective action taken where temperatures are outside of the accepted range. Facility food fridges are monitored weekly. Hot food temperatures are recorded daily. Room temperatures are monitored. There is a cleaning schedule in place (sighted) which is signed off as duties are completed. Staff are observed wearing aprons, hats and gloves.</p> <p>The kitchen equipment is on a planned maintenance schedule. The preferred supplier provides chemicals, safety data sheets and chemical</p>

		<p>safety training as required. Quality control checks are carried out on the dishwasher. Chemicals are stored safely in the kitchen.</p> <p>There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal</p> <p>Feedback on the service is received from resident and staff meetings, surveys and audits.</p> <p>ARHSS D15.2f: There is evidence that there is additional nutritious snacks available over 24 hours.</p> <p>D19.2 Staff have been trained in safe food handling with a refresher provided in May 2014.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The right to appeal against assessment outcome policy states the manager at every stage will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry is referred back to the needs assessors or referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Risk assessment tools and monitoring forms are available and implemented to assess level of risk and required support for residents. Assessments are reviewed six monthly or when there is a change to condition.</p> <p>ARHSS D16.5gii three resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</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>An initial hand written long term care plan is developed which covers all aspects of resident cares and includes assessments, problem/deficits, management and interventions. A V-care long term care plan is developed following the six month evaluation and the nine files reviewed included documented interventions to support care required. Staff have been trained</p>

		<p>for the Vcare computerised resident file system and registered nurses are scheduled to attend InterRAI training. Resident/family/whanau involvement is evidenced by written acknowledgment of care plan involvement.</p> <p>Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist, dietitian and MHSOP. Activity coordinators maintain activity assessment/activity plans and evaluations in residents file. There are specific physiotherapy progress notes and podiatry visits are documented.</p> <p>ARHSS 16.3f: Three resident files reviewed in the psychogeriatric unit identified current abilities, level of independence, identified needs and specific behavioural management strategies. All three residents had comprehensive behaviour management plans that had been reviewed and updated. Activities plans are documented for cover over a 24 hour period to meet the resident's individual needs in relation to diversional therapy, motivational and recreational therapy.</p> <p>D16.3k, Short term care plans are in use for changes in health status. Examples sighted are as follows: skin tear, cellulitis, chest infection and UTI.</p> <p>D16.3f; Nine resident files reviewed identified that the resident/family are involved in the development/evaluation of care plans. Seven relatives interviewed confirm they are involved in the care planning process</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>FA</p>	<p>Residents interviewed report their needs are being appropriately met. Relatives interviewed state the needs are being appropriately met and they are kept informed of any changes to health and interventions required. This is evidenced in the progress notes with a "relative contact" stamp.</p> <p>D18.3 and 4 Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment and wound treatment and evaluation plans are in place. Each unit has a wound and skin tear register on Vcare which details the current wounds; the wound assessments, wound treatment plans and progress and evaluations. Wounds currently being cared for include chronic ulcers, skin tears, lesions, skin cancers, toe infection, excoriation, gout nodules and skin cracks. There is one grade two pressure injury noted for a hospital resident. Short term care plans are in</p>

		<p>place for skin tears. The SCU co-ordinator is the “wound champion” for the service offering advice and education for all staff on wound care management. There is also access to external to wound specialist as required.</p> <p>Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the registered nurses interviewed. Continence management has been attended.</p> <p>Weigh chair scales and wheel on platform scales (both calibrated) are used to weigh residents monthly or more frequently for the monitoring of weight loss/gain. Weight loss short term care plans include drink supplements, food and fluid monitoring, frequency of weighing, frequent in-between snacks and GP/Dietitian notification. Nutritional needs screening tools are evidenced in use.</p> <p>Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour nursing care plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best used to manage behaviours. Behaviour monitoring charts are in place for all special care unit residents to monitor behaviours and the effects of commencement or reduction of psychotropic medications.</p> <p>ARHSS D16.4; There is good specialist input into residents in the psychogeriatric a unit including a mental health consultant and nurse practitioner visits as required. Strategies for the provisions of a low stimulus environment could be described.</p> <p>ARHSS D16.5c; All three files in psychogeriatric unit were individualised, behaviour management also linked to resident goals.</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,</p>	<p>CI</p>	<p>The activities programme at Ryman Yvette Williams is tailored to each service level. Activities are provided over seven days by a team of nine activities staff. The activities provided are appropriate to the resident groups and feedback from residents and families is very positive. The programme is</p>

<p>age, culture, and the setting of the service.</p>		<p>tailored to residents cognitive and physical abilities and interests.</p> <p>ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered, is included in the lifestyle care plan. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least three monthly.</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>The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). Short term care plans are utilised in the rest home, hospital, and psychogeriatric unit. Short term care plans are evaluated regularly and resolved or added to the long term care plan if an ongoing problem. Any changes to the long term care plan are dated and signed. Family are invited to attend the multidisciplinary review meetings (correspondence noted in files reviewed). Resident medications and medical status are reviewed at least three monthly by the general practitioners.</p> <p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. Five of nine long term care plans have been evaluated six monthly. Four residents (three hospital and one rest home) have not been at the service long enough for a long term care plan review.</p> <p>D 16.3c: All initial care plans sampled were evaluated by the RN within three weeks of admission.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>D 20.1: There is a referral policy. Referral to other health and disability services is evident in a sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals are initiated either by the service or the GP. Referrals and options for care are discussed with the family. Referrals sighted on the resident files sampled are as follows: physiotherapy, needs assessor, physiotherapist, speech language therapist, dietitian, wound care nurse, palliative care team and mental health services for the older person.</p> <p>D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care</p>

		such as respite care to rest home level of care and rest home care to hospital level care.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry, housekeeping and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly. Safety data sheets are available. Staff attend chemical safety training. This is also included in staff orientation.</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 service displays a current building warrant of fitness which expires on 14 October 2015. The service is divided into three floors with the special care unit on level one, hospital on level two and serviced apartments on level three. There is a central reception area, a large communal lounge and dining room for apartment residents. Each unit in the care centre has a lounge and dining area with the hospital divided into two smaller areas each with kitchen/server, dining and lounge areas. The maintenance team address any maintenance requests or call in contractors as required. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and electrical testing – all of which are current. There is a gardening team responsible for the grounds and gardens. The maintenance team attend the facility meetings which include maintenance and preventative maintenance. Hot water temperatures in resident areas are monitored monthly and stable between 38-44 degrees Celsius. Internal audits for water temperatures have been conducted three monthly.</p> <p>The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. There is adequate space around the facility for storage of mobility equipment.</p> <p>There is an outside area with shade and seating that is observed to have well maintained paths. The special care unit has an open courtyard terrace</p>

		<p>with seating and raised garden beds and boxes.</p> <p>ARHSS D15.3d The lounge area is designed so that space and seating arrangements provide for individual and group activities.</p> <p>ARC D15.3; ARHSS D15.3e: The following equipment is available, pressure relieving mattresses, shower chairs, standing and lifting hoists, mobility aids, transferring equipment, sensor mats, electric beds, ultra-low beds, and hospital level specialised lazy boy chairs on wheels and weighing scales. Interviews with caregivers from the psychogeriatric unit confirmed there was adequate equipment.</p> <p>ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.</p> <p>ARHSS D15.3b There is a safe and secure outside area that is easy to access. The lounge area is designed so that space and seating arrangements provide for individual and group activities.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms have full ensuites. Communal toilets are located near the lounges. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each area has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library available for quiet private time or visitors. There are communal areas. There is a separate dining area in the large open plan living area in the secure unit.</p> <p>ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Laundry chemicals are within a closed system to the washing machine. Material safety data sheets are displayed in the cleaning cupboards and there is secure chemical storage areas. There are two laundry staff on each day and one in the evening. All linen and personal clothing is laundered on- site. The service has introduced a new initiative of heated labelling system for all clothing that is carried out by laundry staff. Individual named linen bags are being placed in the resident's rooms so that clothing can be checked for name labels as they are sorted. The laundry and cleaning areas have hand-washing facilities. Cleaner's trolleys are well equipped. All chemical bottles have the correct manufacturer's labels. Housekeeping staff carry the chemical bottles in a caddy with them when cleaning bedrooms and ensuites. External contractors clean the carpets, vinyl and furnishings on a three monthly cycle and all windows as per schedule.</p> <p>Residents interviewed state they are happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing is treated with care and is returned to them in a timely manner. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The Ryman group emergency and disaster manual includes (but not limited to) dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Emergencies, first aid and CPR is included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. Yvette Williams has an approved fire evacuation plan – letter dated April 2011. Fire drills are scheduled for staff during</p>

		<p>induction and six monthly. The last fire drill was held in November 2014. Smoke alarms, sprinkler system and exit signs in place. As per Ryman policy, staff are required to complete emergency response training every two years and emergency procedures are included in orientation. There is a first aid trained staff member on every shift.</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The service has alternative cooking facilities (gas cooker) available in the event of a power failure. Battery operated emergency lighting is in place for two hours. There are also extra blankets available. There is a civil defence kit for the whole facility and stored water. There is a civil defence folder that includes procedures specific to the facility and organisation. Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. Senior caregivers carry a pager and all calls are signalled on a screen with the room number at varied places throughout the facility. The "Austco Monitoring programme" is available in each bedroom and ensuite to ensure the resident is effectively monitored with dignity and limited interruption. The system includes a nurse presence bell system, when a nurse/carer is in the resident room a green light shows staff outside. The serviced apartments also include call bells in resident rooms and ensuites. Those residents assessed as requiring rest home level care in the serviced apartments are given a call bell pendant so that a call bell is always accessible. There is an entrance and reception area on entering the units via a lift/stairs. The entire facility is secured at night. The service utilises security cameras and an intercom system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility and a DVS ventilation system in place. Heating in individual rooms can be adjusted and set. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description. A registered nurse is the designated IC officer. There is an implemented infection control programme that is linked into the</p>

		quality management system. Infection control matters are integrated with the bimonthly health and safety meetings and the infection control committee includes a cross section of staff. The facility meetings – RAP committee, staff, registered nurse, full facility, management - also include a discussion and reporting of infection control matters. Information from these meetings is passed onto the staff meetings. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. An outbreak was reported in August 2013.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control committee is made up of a cross section of staff from areas of the service including; (but not limited to) the village manager, the clinical manager, registered nurses (one of whom is the IC officer); kitchen, laundry and housekeeping staff. The infection control committee is combined with the health and safety committee. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are comprehensive infection control policies that are current and reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practise. These are across the Ryman organisation and are current and regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate. There are policies for IC management, b) implementing the IC programme, c) education, d) surveillance, and e) IC policies and procedures related to the prevention of transmission of infection.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control officer is responsible for coordinating/providing education and training to staff. The IC officer (registered nurse) has appropriate IC training for the role (Ministry of Health online training in 2014). The induction package includes specific training around hand washing and standard precautions and the IC officer provides training both at orientation and ongoing. Training on infection control was last provided November 2014. Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in

		ensuring this occurs.
<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 describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the RAP. The results are subsequently included in the village manager's report. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 currently has seven hospital residents who have been assessed as requiring the use of a restraint (bedrails and/or chair belt) and one hospital resident with an enabler (bedrails and lap belt). There are two residents in the special care unit (psychogeriatric) who require restraint in the form of a lap belt. All restraint is utilised as a falls prevention measure. 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.</p> <p>Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval and review process. The</p>

		<p>coordinator of the special care unit (RN) is the restraint officer. Types of restraint have been approved for use by the restraints committee. The service is able to evidence a successful trial of removal of restraint. Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice is included in the core competencies and dementia course modules. Staff have attended restraint in-service within the last year.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint officer is the special care unit coordinator (registered nurse) and has been in the role for five years. The restraint officer has completed restraint training. There is a restraint officer's job description. The approved restraints (bedrails and lap belts) are documented in the restraint policy. Restraint and consent is in consultation/partnership with the resident (as appropriate) or whanau, the restraint officer, GP and another RN. There is provision for emergency restraint following consent from family/whanau.</p> <p>Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Staff complete incident forms and report any accidents/incidents to the RN/Restraint officer in regards to restraint use and these are discussed at the RN and management meeting and corrective actions initiated. Frequent fallers are identified through the accident/incident data collated. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised.</p> <p>Each episode of restraint is monitored at pre-determined intervals (as per the long term care plan) depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated at least six monthly or earlier if required. The restraint monitoring form includes codes for care delivered throughout the restraint episode and this is recorded on the monitoring form. The residents file refers to specific interventions or strategies to try (as appropriate) before use of restraint. Care plans reviewed for one hospital and one special care unit residents with restraint, and one hospital resident with an enabler, identified observations and monitoring occurring within the prescribed timeframes documented on individual residents' restraint assessment.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Restraint assessments are undertaken by the restraint officer or registered nurse in partnership with the resident and their family/whanau. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the resident/family/whanau and GP. Three resident files reviewed of residents with restraint/enabler evidenced a risk assessment, consent form and three monthly evaluations. All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed by the Restraint officer and restraint committee.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the restraint co-ordinator at least six monthly or earlier if required as part of the three monthly medical review. Families are included in restraint review as part of the long term care plan review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and restraint committee (special care unit co-ordinator, infection control officer, hospital and GP). Advised that restraint is viewed as the last resort and least restrictive option. Restraint in use is part of falls prevention and for safety and security measures.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the restraint co-ordinator at least three monthly or earlier if required as part of the three monthly medical review. Families are included in restraint review as part of the long term care plan review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and restraint committee (hospital unit co-ordinator, infection control officer, hospital and GP). Individual restraint use is monitored and recorded by care staff. The policy clearly states the timeframes for monitoring with a minimum of two hourly checks overnight when bedrails are in situ. Those residents with a lap belt are monitored half hourly for safety, comfort,</p>

		distress, agitation, food and fluids and two hourly for exercise, change of position, toileting and activities.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least three monthly as part of the medical review and six monthly as part of the long term care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint officer. Incident/accidents are reviewed by the restraint officer. Corrective actions are monitored. There is a monthly restraint officer report (including the hours of restraint) is sent to head office. Restraint is discussed at all clinical and management meetings. Issues/concerns are discussed at the meetings (minutes sighted). Restraint use is linked to the Ryman Accreditation programme (RAP). Individual restraint use is monitored and recorded by care staff.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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>Yvette Williams is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. Repeat audit is required if results exceed the Ryman threshold (90%). Issues and outcomes are reported to the appropriate committee e.g. RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – e.g. falls rates. Weekly reporting to the regional manager includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix. QIP’s reviewed are seen to have been closed out once resolved. The QIP process is seen to have been well embedded into day-to-day operations at Yvette Williams and include clinically focused improvements.</p>	<p>Quality improvement activity at Yvette Williams is guided by the Ryman Accreditation Programme (RAP) framework. To this end the facility has identified a number of objectives for the 2014 year. Objectives are clustered against four distinct groups – resident satisfaction, clinical, human resources and health and safety. Objectives against each area are outlined in the following:</p> <ul style="list-style-type: none"> a) Resident: decrease the call bell response time, ensure a prompt response to complaints, and improve satisfaction in relation to laundry services. b) Clinical: reduce the number of falls to below the national indicator rate. c) Human resources: reduce staff turnover to below 25%

			<p>d) Health & Safety: reduce work related injuries and reduce sick leave</p> <p>Progress towards objectives is reported regularly (quarterly) with the last minute discussion in August. Updates are noted to filter through the meeting structure – management meetings, full facility RAP, clinical meetings. In addition to general discussion about the objectives, the various meetings also discuss progress towards the Quality Improvement Plans (QIPs). In the case of Yvette Williams these two processes are generally linked. The following focus on the resident and clinical QIPs and provide a number of examples that demonstrate the facility is proactive in using the QIP process to improve outcomes for residents.</p> <p>a) Resident: call bells – this QIP was developed in response to complaints and feedback around call response times. A daily call bell report is provided to the village manager. The report is also discussed at handover with a focus on those residents who use the call bell more frequently. The service has trained staff and implemented a system of intentional rounding. This system ensures frequent checks are made of residents who require higher levels of care and reassurance. Staff advise residents when they are on a break and when they will be returning. Staff are prompt at answering call bells and returning to residents as promised. The August review of this QIP has seen a reduction in the call bell response time. Complaints/care – in response to the number of complaint received in 2013 a QIP was developed by the village manager. In the August QIP review, there has been a reduction in the number of complaints received for 2014 (16 in 2013, 11 for 2014). A QIP was developed focusing on communication with residents and families, one of</p>
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			<p>the action identified was education with staff and evidence of this having occurred is seen in the training records (therapeutic relationships training July 2014). Complaints have been discussed at the various staff meetings (minutes sighted). The complaint information reports relative satisfaction with the approach taken and outcome. The resolution time for complaints management is now at three weeks. Laundry – a new system of labelling laundry has been rolled out throughout Ryman homes in response to resident and relatives complaints of lost items of clothing. The labelling system ensures that all residents clothing is labelled in the laundry and each resident now has individual laundry bags so that personal items do not get mixed up with other residents clothing. Complaints around missing laundry items have now ceased as evidenced in resident interviews and meeting minutes.</p> <p>b) Clinical: a QIP around reducing the incidence of falls was developed in response to falls rates. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, hi/lo beds, assessment and exercises by the physiotherapist and sensor mats. The service has increased the physiotherapist assistant hours to focus on strength training. A physio led in-service was held in April on moving and handling and use of transfer belts and falls prevention training was provided in September 2014. A falls focus group was established and meets monthly to discuss falls incidence, trend analysis, review of roster re times of falls, .GP review of residents re medications. A falls champion was nominated.</p>
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			<p>Residents are encouraged to attend the 'Triple A' exercise group. A programme aimed at encouraging walking (walk with me) has been implemented for residents who are restless and at risk of unsafe mobilisation. Staff were able to describe their practice in frequent accompanied walks with residents at risk – especially in the special care unit. The results over 2014 are positive with a reduction in the rate of falls for special care unit residents – 13 falls for the month of January with a steady decline over the year. In October there was one fall in the SCU and two for November 2014. In the hospital unit there has also been steady decline since June 2014 with 28 falls recorded (most attributed to 1-2 residents) and six falls reported for October, 14 for November. Falls protocols are in place to response to falls with and without injury. All staff are involved in actively reducing the rate of falls with housekeepers conducting spot checks of alarm mats, a weekly falls report given at handover times, and intentional rounding to pre-empt residents who may attempt to mobilise unaided.</p> <p>Full review of all facility QIP's will be conducted in December 2014. While these are only a small number of the total QIPs the facility had in place there is sufficient evidence to demonstrate that as a team they are responsive to resident/ relative feedback and take a quality cycle approach to improving resident outcomes.</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills,</p>	<p>CI</p>	<p>There are nine activity coordinators at Ryman Yvette Williams who provide a separate activity programme for the rest home, hospital, special care unit and serviced apartments. The activities programme is provided for seven days a week in the facility by a</p>	<p>The facility has adopted three Ryman initiatives: the Triple A exercise programme; "Spice of life"- a resident focused programme to enable the village to support residents achieve self-setting goals; and the 'Engage at Ryman' programme which</p>

<p>resources, and interests) that are meaningful to the consumer.</p>		<p>combination of full time, part time and casual staff. Residents in the village apartments are involved in the activities programme. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The Engage at Ryman programme is being included in the programme and participation has increased since its commencement, the programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility</p>	<p>encourages participation rather than observation. The combination of these three strategies has markedly increased resident participation in all units. Residents and families interviewed were excited about the new approach, the diversity of the programme and the improvement it had made to the quality of life. One on one time is spent with residents who choose not to participate or who choose not to join in group activities. The one on one activity is planned individually and is as varied as growing seedlings to learning to crochet. Village residents are encouraged to be involved in the activities in the care centre at Ryman Yvette Williams and many help as volunteers including fund raising and visiting.</p> <p>The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility. Residents are encouraged to maintain links with the community and there is contact with groups such as pre-school groups, school groups, concerts, RSA, library, music and dancing and Church services. There are regular outings and scenic drives for residents in all units. The service has an eleven seat van and a mobility taxi is hired to ensure hospital level residents (wheelchair bound) have an opportunity to go out. Festive occasions, special events and resident birthdays are celebrated. Activities in the dementia unit are individualised and based on sensory activities and normal daily activities. The programme is reviewed weekly with Triple an attendance sheets being forwarded to head office. The activity team described the implementation of the 'Spice of Life', a resident focused programme to enable the</p>
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			<p>village to support residents achieve self-setting goals. Resident meetings and surveys provide feedback on the activities programme. All residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Village residents are encouraged to be involved in the activities in the care centre at Ryman Yvette Williams and many help as volunteers including fund raising and visiting. There are nine activity coordinators at Ryman Yvette Williams who provide a separate activity programme for the rest home, hospital, special care unit and serviced apartments. Morning and afternoon activities are provided for seven days a week in the facility by a combination of full time, part time and casual staff.</p>
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End of the report.