

Edmund Hillary Retirement Village Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Edmund Hillary Retirement Village Limited
Premises audited:	Edmund Hillary Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 January 2015 End date: 9 January 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	189

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Edmund Hillary Retirement Village is a Ryman Healthcare facility, situated in Auckland. The Edmund Hillary facility is modern, spacious and extends across three levels. The facility provides rest home (including 40 certified serviced apartments), hospital and dementia level care for up to 225 residents. On the day of audit there were 58 rest home residents in the care centre and 13 rest home residents in the serviced apartments; 100 hospital residents and 18 residents in the special care unit (dementia). The village manager is suitably qualified and supported by a clinical services manager (registered nurse) who oversees the care centre.

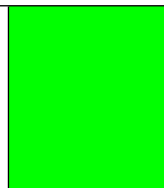
There are systems in place that provide appropriate care for residents. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The service had addressed all eleven shortfalls from the previous certification audit around: strategies to manage clinical trends, review of the quality improvement plan, notifying the Ministry of Health of increased numbers in the dementia unit, staff appraisals, pain assessments, care plan interventions, evaluation of short term care plans, documentation of as required medication, meeting residents food likes and dislikes and chemical storage.

This surveillance audit also identified improvements required around care plan interventions, activity plan evaluation and management of residents self-medicating.

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.

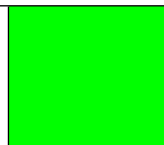


Standards applicable to this service fully attained.

There is an open disclosure policy. Interviews with residents and relatives confirmed family are kept informed of their family member's current health status. A complaints process was being appropriately implemented.

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.

Edmund Hillary is implementing the Ryman Accreditation Programme that provides the quality and risk management framework for residential services. Edmund Hillary has quality objectives throughout the year and all components of the quality management system link to a number of service meetings. The findings from the previous audit relating to meeting minutes and review of the quality programme are now met. An annual resident/relative satisfaction survey was completed and there were regular resident/relative meetings. Edmund Hillary collects clinical indicator data for the three services being provided (hospital, rest home and dementia). Incidents are entered directly into the electronic reporting system. The service was aware of required reporting to regulatory authorities and the finding from the previous audit is now closed. There are human resources policies including recruitment, selection, orientation and staff training and development. Performance appraisals were current and the finding from the previous audit is now closed. There was an induction programme being implemented and an in-service training programme covering relevant aspects of care. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care plans and evaluations reviewed were completed by the registered nurses within the required timeframe. Monitoring forms were being utilised. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Short term care plans were in use for changes in health status. The activity coordinators provide an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community. There were 24 hour activity plans for residents in the special care unit that were 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 an 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

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Standards applicable to this service fully attained.</p>
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The service displayed a current building warrant of fitness. Chemicals were appropriately labelled and stored safely throughout the facility. The finding from the previous audit has been met.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are comprehensive policies and procedures that meet the restraint standards. There is a restraint officer (registered nurse) with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail is appropriate for the size and complexity of the service. The infection control officer (registered nurse) used the information obtained through surveillance to determine infection control activities and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. In-service education was included as part of the annual training programme. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	2	1	0	0
Criteria	0	40	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Edmund Hillary continues to implement the Ryman complaints policy. The village manager has overall responsibility for managing the complaints process including ensuring an appropriate investigation is undertaken. A complaint register records the number, type and date of resolution of complaints received. The 2014 complaints were reviewed and all documentation including follow up letters and resolution was available. The number of complaints received each month was reported monthly to staff via the various meetings – e.g. Caregivers, full facility, registered nurse. Discussion with six residents and eight relatives confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff around their responsibility for open disclosure. Edmund Hillary has been moving to electronic reporting of incidents into the Ryman VCare system. Staff are required to record family notification when entering an incident into VCare and the incidents reviewed met this requirement. Eight family members interviewed (one rest home, five hospital and two from the special care unit) confirmed they were notified following a change of health status of their family member. There is an interpreter policy and contact</p>

		<p>details of interpreters are available. The information pack is available in large print and this could be read to residents. The residents and family stated they were informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.</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>Edmund Hillary is a Ryman Healthcare retirement village. The facility is built across three floors and is designed around a large atrium and courtyards. The service provides dementia (special care unit), rest home (including 40 certified serviced apartments) and hospital level care for up to 225 residents. Occupancy on the day of audit was 189 residents – 18 in the dementia unit, 71 rest home (of which 13 are in the serviced apartments) and 100 hospital level residents. There is a contracted physiotherapist that provides 15 hours a week and two physiotherapy assistants five days a week. There is a contracted medical centre that provides daily services to Edmund Hillary. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimised risks.</p> <p>There is a documented ' purpose, values, scope, direction and goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives from an organisational perspective are set annually and each service then develops their own objectives. Edmund Hillary had objectives for 2014 that had been reviewed as prescribed in the Ryman Accreditation Programme (RAP). 2015 objectives were in the process of being confirmed at the time of audit.</p> <p>The village manager at Edmund Hillary - who was on leave at the time of audit – has been in the role for approximately two years, and has a background in retail management. He is supported by an assistant manager who carries out administrative functions and a clinical services manager (registered nurse) who oversees clinical care. The clinical services manager had had previous experience at one of the District Health Board's and had been in post since May 2014. The management team is supported by the wider Ryman management team that included a regional manager. The village manager and clinical services manager had maintained at least eight hours of professional development activities related to managing a village.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Edmund Hillary continues to implement the RAP which links key components of the quality management system to village operations. The RAP Committee meet monthly at Edmund Hillary. Outcomes from the RAP Committee are then reported across the various meetings including the full facility, registered nurse and caregivers. Issues are also discussed at the monthly management meetings with reporting going through to the regional manager. Meeting minutes included discussion about the key components of the quality programme including policy, internal audit, training, complaints and quality improvement plans (QIPs). The finding from the certification audit is considered to be closed.</p> <p>Policy review is coordinated by Ryman head office. Facility staff have the opportunity to provide feedback during the review process. Policy documents have been developed in line with current best and/or evidenced based practice. All facilities have a master copy of all policies and procedures and the associated clinical forms. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence. There are also education packages being implemented at Edmund Hillary that are based on Ryman policies.</p> <p>The RAP prescribes the annual internal audit schedule that was being implemented at Edmund Hillary. Audit summaries and QIPs were completed where a noncompliance is identified. Repeat audits were also undertaken to determine if improvements had resulted from the QIPs. Issues and outcomes were reported to the appropriate committee e.g. RAP.</p> <p>Monthly clinical indicator data was collated by the quality coordinator (registered nurse) across the rest home (including rest home residents in the serviced apartments), dementia unit and hospital services. There was evidence of trending of clinical data, and development of QIPs when volumes exceeded targets – eg. falls and pressure injuries. Falls prevention strategies were in place that included, hi/lo beds, on-going falls assessment and exercises by the physiotherapist, and sensor mats. QIP's have also been developed to address issues raised through the 2014 resident/relative survey. QIP's reviewed were seen to have been closed out once resolved. Interview with staff confirmed an understanding of the quality programme. The finding from the certification audit relating to review quality outcomes has now been closed.</p> <p>There was a health and safety, and risk management programme being implemented at Edmund Hillary. The Edmund Hillary health and safety and</p>
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		infection control committees met bimonthly and included discussion of incidents/accidents and infections. There was a newly appointed health and safety representative who has training scheduled in February (2015). There is a current hazard register.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Edmund Hillary collects incident and accident data and was in the process of moving from manual to electronic recording of events. Incidents have been reviewed in the electronic VCare system. There was the ability to indicate when an incident is still open for either monitoring or investigation. These incidents are recorded as – ‘unresolved’. VCare Live has the ability to generate an aggregated list of unresolved incidents and at the time of audit a manual record was being maintained mitigating any risk.</p> <p>Edmund Hillary was in the process of moving from a manual to an electronic system for recording resident incidents. All incidents will eventually be recorded into the VCare system. The system recorded detail such as the type of incident, action taken, that the next of kin were notified and any outcome. There was a field in the system to record whether the incident was ‘resolved’ or ‘unresolved’. Monthly trending reports are generated from VCare for the service and QIPs are required to be developed and actioned where trends exceed expected volume</p> <p>Monthly analysis of incidents by type is undertaken by the quality coordinator and reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and this has been used for comparative purposes. QIPs have been created when the number of incidents exceeded the benchmark. QIPs at Edmund Hillary included falls and pressure injuries. QIPs were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. The finding from the certification audit is considered to be closed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are also job descriptions for the infection control coordinator, restraint coordinator, in-service educator, health and safety officer, fire officer. Appropriate recruitment documentation was seen in the 13 staff files reviewed (one diversional therapist, one chef, five caregivers who work across the service areas, five registered nurses one receptionist who is the newly appointed health and safety representative). A register of practising certificates has been maintained. Performance appraisals were current in all files reviewed and the finding from the certification audit is now met. Interview with the management team</p>

		<p>(assistant village manager, clinical services manager and quality coordinator) inform a stable workforce. Interview with nine care givers and six registered nurses inform management were supportive and responsive.</p> <p>There is an annual training plan aligned with the RAP that was being implemented. There is a registered nurse who oversees staff in-service and the ACE programme. Participation in the ACE programme is a requirement for caregivers. Ryman ensures registered nurses (RNs) are supported to maintain their professional competency. There is an RN journal club that meet two monthly at Edmund Hillary and subjects covered include (but not limited to) pressure injury prevention and care. Ryman has a 'Duty Leadership' training initiative that all registered and enrolled nurses and senior leaders complete.</p> <p>There is an induction programme being implemented with completion being monitored and reported monthly to head office as part of the RAP programme. Interview with staff informed the induction programme meets the requirements of the service.</p> <p>The clinical structure in the facility includes a clinical services manager, registered nurse coordinators in the various service areas and a team of registered nurses and care staff. The serviced apartments (where there were 13 rest home level residents) also had a coordinator (registered nurse). In the dementia unit there were eight of ten care givers employed to work in the dementia unit who had completed dementia standards. The remaining two were in the process of completing.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Ryman has policies to guide services in respect of skill mix, staffing ratios, rostering and on call requirements. There is at least one registered nurse and first aid trained member of staff on every shift. Rosters reviewed met ratios as outlined in organisational policy. The senior management team were interviewed in respect of staffing and informed one of the 2015 goals is to consider the model of care at the service by undertaking a detailed review of call bell response time and trending of resident incidents by time, type and location. This piece of work had commenced at the time of audit. Interviews with nine caregivers informed the registered nurses are supportive and approachable. The caregivers and six registered nurses informed there are generally sufficient staff on duty at all times. Likewise interviews with six residents and eight relatives informed sufficient staff on duty to meet needs.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</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. All medication is managed appropriately in line with required guidelines and legislation. The service uses individualised medication blister packs for regular medications and PRN medications. Indications for use of prn medication are recorded and the finding from the previous audit is met. Medication packs have been checked against the medication chart on delivery by a registered nurse and this is recorded. All medications rooms are secure.</p> <p>Staff attend medication administration training and have completed medication and insulin competencies. RNs have completed syringe driver training. There are three self-medicating resident in the rest home with a current competency and assessment completed. Reviews are conducted three monthly. Self-medicated medicines include inhalers, nasal spray and GTN spray. These carried by the resident. There is no evidence of monitoring of self-administration of these medications. Medication administration is observed to be compliant in all units during the audit.</p> <p>Medications to be returned to the pharmacy are stored securely until collected by the pharmacy. Medication fridge's are monitored weekly (records sighted). Oxygen, suction and emergency trolley in the hospital unit is checked and signed off (as sighted). There are no gaps identified on the 24 medication charts reviewed.</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>Ryman has a comprehensive food services manual that includes a range of policies relating to all aspects of food procurement, storage, handling, menus, dishwashing, sanitation, personal hygiene and special diets. The RAP prescribes the frequency of audits in the kitchen including fridge and food temperature monitoring. The RAP also prescribes the frequency of in-service education. These aspects of the quality programme were being implemented as scheduled at Edmund Hillary. The menu had been designed and reviewed by a registered dietitian at an organisational level. All food was produced on site and the kitchen was spacious. Food in the pantry, fridge and chillers were covered and dated. Diets can be modified as required. There was a choice of foods and the kitchen could cater to specific cultural requests if needed. The chef interviewed confirmed alternatives could be provided for residents if requested.</p> <p>All residents had a nutritional profile completed on admission and provided to the kitchen. These were reviewed six monthly as part of the care plan review or as needs changed. The staff interviewed described how changes to residents' dietary</p>

		<p>needs were communicated to the kitchen. Special diets and resident likes/dislikes were noted on the kitchen notice board. Meals were delivered to the kitchenette in each of the units and care givers served the meals. Care givers across the service types (rest home, hospital and dementia) described how they ensured residents likes and dislikes and dietary requirements were met. Food and fluid folders (sighted) were kept in the kitchenette that details the resident dietary requirements. The finding from the certification audit has been met. There is evidence that there are additional nutritious snacks available over 24 hours.</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>The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food & nutrition information and mental function. Risk assessment tools and monitoring forms were available including (but not limited to): falls, pressure area, continence, nutrition, pain and challenging behaviour.</p> <p>Resident files reviewed included assessments completed to assess level of risk and required support for residents. Assessments were completed on admission, reviewed six monthly or when there was a change to condition. The previous finding in relation to pain assessments is now closed out.</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>Care plans are evaluated six monthly and when the health status changes. Three resident files were not updated when health status changed (link 1.3.6.1). Staff have been trained for the Vcare computerised resident file system and RNs are scheduled to attend InterRAI training.</p> <p>Short term care plans were in use for changes in health status. Examples sighted are as follows: skin tear, cellulitis, chest infection and UTI. The previous is now closed out. The facility has a company wound specialist who visits for two full days a week and more as required. All wounds are viewed and management plans formulated and documented fully. The management of all wounds and minimisation of pressure areas has improved. The previous finding in relation to pressure area prevention and, management and minimisation is now closed out. Two of the files sampled had weight loss. Both had timely referrals to the dietitian and regular GP input. Weighing frequency was increased and all instructions from the dietitian and</p>

		<p>GP followed.</p> <p>Behaviours charts were used daily in the special care unit and for any residents in other units that exhibit challenging behaviours. These behaviours, their triggers and de-escalation techniques were well identified through the assessment process with management plans implemented with evidence of regular evaluations in all but two files sampled. The previous finding around behaviour assessments has been closed out. (also link 1.3.6.1)</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Residents interviewed report their needs were being appropriately met. Relatives interviewed state their relatives 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>Wound assessment and wound management plans/skin tear plans are recorded and stored on the computer based Ryman VCare system in each unit. There is a register of wounds and a daily prompt of dressing due for evaluation is generated automatically. The facility has a Ryman Wound Specialist (interviewed) who visits the facility for two days a week and assesses wounds as well as conducting one on one, informal small group and scheduled education sessions. There has been a reduction in wounds since the wound specialist has been overseeing the facility. The wound specialist views all wounds on the two days she is on site and advises staff on treatment, the GP is also involved in the care of chronic wounds. The RN's interviewed (six) value the expertise of the wound specialist and the teaching she provides them. Dietitian referrals are evident in the residents with chronic or pressure area wounds.</p> <p>Resident weights have been recorded monthly and monitored by the unit co-ordinators of each unit. Residents with weigh loss or gain have a weight loss/gain document completed that identifies weight management interventions including increase in weighing frequency, GP notification, mini nutritional assessments and reviews, dietary supplements, additional high calorie snacks, food and fluid monitoring and dietitian referral if required. Weight loss short term care plans were sighted in the files of two residents with weight loss. There is evidence of weekly weighs as instructed, GP notes and dietitian referral and correspondence. Food and fluid charts were in place. The families have been notified of their relative's weight loss as documented in the resident records. Wound care has been integrated into the long term care plan and any interventions and assessments documented in the progress notes.</p>

		<p>There was documented evidence in the resident files sampled that GP instructions in medical notes have been followed such as blood sugar monitoring, weight monitoring, pain management, catheter management and wound management.</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 six registered nurses interviewed.</p> <p>Weigh chair scales (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>Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment form for at risk residents. Accident /incidents are investigated for cause and corrective actions including a physiotherapist review, the use of sensor mats, hip protectors, clutter free rooms and mobility aids available.</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. Two residents with identified challenging behaviours did not trigger identified in their long term care plan. Behaviour monitoring charts are in place for all special care unit residents to monitor behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are eleven activity coordinators at Ryman Edmund Hillary who provide a separate activity programme for the rest home, hospital, special care unit and serviced apartments. Two of the activity staff are registered diversional therapists (DT) and two are currently working towards this qualification. The activities programme is provided for seven days a week in the special care unit and the hospital unit, and Monday to Friday in the rest home and service apartments' area. There were set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of</p>

	<p>the resident group. 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>The resident is assessed and with family involvement if applicable and likes, dislikes, hobbies, and past interests are discussed. A plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities assessment, 'your life experiences', next of kin input into care and an activities plan (link 1.3.8). The plan includes categories for comfort and wellbeing, outings, interests and family and community links. There is a comprehensive programme that meets the needs of all consumers including but not limited to; news, reminiscing, triple an exercises, lounge games, carpet bowls, arts and crafts, board games, happy hours and weekly sing-a-longs and entertainers. Units mix and mingle for special events and happy hour as desired. One on one time is spent with residents who choose not to participate or who choose not to join in group activities.</p> <p>Residents continue to be encouraged to maintain links with the community and community groups visit, such as pre-school groups, school groups, concerts, community singing groups, RSA, library, music and dancing. Church services are held weekly. There were regular outings and scenic drives for residents in all units. Residents in the dementia care unit are taken for supervised outdoor walks and scenic drives. Activities in the dementia unit are individualised and based on sensory activities and normal daily activities. The programme is reviewed weekly with Triple A 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 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 have been encouraged to be involved in the activities in the care centre at Ryan Edmund Hillary and many help as volunteers including fund raising and visiting.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in resident files). Short term care plans were utilised in the rest home, hospital, and dementia unit. Short term care plans have been evaluated regularly and resolved or added to the long term care plan if an on-going problem. Any changes to the long term care plan have been dated and signed. Family are invited to attend the multidisciplinary review meetings (correspondence noted in files reviewed). Resident medications and medical status have been reviewed at least three monthly by the general practitioners. The previous finding in relation to STCPs being evaluated and signed off as resolved is now closed out.</p> <p>Activities care plans are evaluated six monthly in conjunction with the long term care plan (LTCP) review. Two residents did not have their activities care plans evaluated six monthly.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness that expires 13 August 2015.</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>Edmund Hillary implements the Ryman policies and procedures which included regular audit and auctioning of QIPs when required. There was a secure area for the storage of cleaning chemicals in all service areas and in the laundry. Laundry chemicals were within a closed system next to the washing machine. The laundry and cleaning areas had hand-washing facilities. Material safety data sheets were displayed in the cleaning cupboards. Cleaning chemicals were all seen to be labelled and trolleys were not left unattended. The finding from the certification audit is considered to be closed.</p>
<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>	<p>FA</p>	<p>The infection control programme was linked to the RAP. The surveillance policy described and outlined the purpose and methodology for the surveillance of infections. Systems in place were appropriate to the size and complexity of the facility. The infection control officer (registered nurse) used the information obtained through surveillance to determine infection control activities such as internal audit and education in the facility. Individual infection report forms were completed for all infections and included on a monthly register. A monthly report was completed and reported through the combined health and safety and infection control meetings. Staff were informed through the variety of meetings held at the facility. There was close liaison with the GP's who advise and provide feedback /information to the service. The service managed two norovirus outbreaks during 2014.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 service has six residents who had been assessed as requiring the use of a restraint (bedrails and/or table) and seven residents an enabler (bedrails and/or table). A monthly restraint and enabler register has been maintained. The long term care plan (under safety/risk) included the use of restraint/enablers, frequency of monitoring and required documentation. The restraint coordinator is a registered nurse and the GP has been involved in the restraint approval and review process. Types of restraint have been approved for use by the restraint committee. Challenging behaviour and restraint minimisation and safe practice was included in the in-service education programme.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	Three residents have been assessed and authorised as competent to self-administer medication, these assessments and competencies have been reviewed three monthly by the GP.	Three of three self-medicating residents did not have evidence of monitoring and recording the administration of these medications. The medications included Ventolin inhalers and GTN and were carried by the residents on their person. The risk is therefore considered to be low.	<p>Documentation of self-medicating residents use of their medication must be recorded every shift as per policy.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>(i). Two of four residents with behaviour care plans had triggers and minimising techniques identified in the LTCP.</p> <p>(ii). Eight of eleven files reviewed had LTCPs evaluated six-monthly and when changes in health status occurred.</p>	<p>(i). Two of four residents with behaviour care plans did not have triggers or minimisation of these identified in the LTCP.</p> <p>(ii). Three residents with changes in their health status did not have their LTCP evaluated.</p> <p>(iii). One married couple did not have details updated in the LTCP.</p>	<p>(i). Triggers and minimisation of these to be included in LTCP's of all residents with behaviour management plans.</p> <p>(ii). LTCPs to be updated when a change in health status occurs prior to the scheduled evaluation.</p>

		(iii), One of two married couples had their spouse and guidelines for their needs, including providing private time together in both LTCPs.		(iii).LTCP's to include a social, privacy and intimacy needs in LTCPs of both residents when they are partners/spouses. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Nine of eleven resident files had activities plan evaluated six monthly.	Two of eleven resident files did not have evidence of six monthly activities plan reviews.	All activities care plans to be evaluated six monthly in conjunction with the LTCP. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.