# Julia Wallace 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Julia Wallace Retirement Village Limited

**Premises audited:** Julia Wallace Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 9 February 2015 End date: 10 February 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:** 94

# 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 |
|  | 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

Julia Wallace Retirement Village is operated by Ryman Healthcare Ltd. The service provides rest home, hospital (geriatric/medical) and dementia level care for up to 104 residents. On the day of audit there were 94 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

There has been a change in village manager and clinical manager since the previous certification audit. She is supported by a clinical manager who is a registered nurse with a current practising certificate. The clinical manager has been previously employed as a manager in a DHB and in aged care. They are both supported by an assistant manager who assists with administration matters including rostering. The hospital, rest home and special care (dementia unit) services are managed by registered nurse coordinators, which is a change that was implemented in late 2013. The serviced apartments are coordinated by an enrolled nurse.

There is an organisational wide quality management system in place. The service has been actively working on reducing the numbers of residents who are experiencing skin tears through injury and improving the overall resident and relative experience through the involvement of pet therapy in the activities programme.

There are two areas of continuous improvement awarded around the implementation of actions aimed at minimising injuries to residents and the activities programme. Improvements are required around aspects of care planning documentation.

## Consumer rights

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| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (i.e., the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive on-going training about the Code. The personal privacy and values of residents are respected. There is an established Maori Health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. There is an established system for the management of consumer complaints in place. The service used benchmarking evidence to determine the need to improve practice in the management of residents who were sustaining skin tears through accidental injuries. All care staff are now required to demonstrate competency each year in correct manual handling techniques. This change in practice has resulted in a significant reduction in the number of skin tears. The service is awarded a continuous improvement for its manual handling programme.

## Organisational management

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| --- | --- | --- |
| 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. |

Ryman Healthcare management team provide governance and operational support to the facility. They ensure that the services provided at the village are planned and coordinated to meet the needs of residents and that staffing is maintained at an appropriate level to meet residents’ needs.

There is an established quality and risk management system in place that is overseen by head office and is outlined in the Ryman Accreditation Programme (RAP) which includes monitoring of resident satisfaction including complaints management, internal auditing, adverse clinical events, infections, and health and safety events. The performance of the village is benchmarked to other Ryman facilities. Performance is reported at facility meetings. There are policies and procedures in place for human resources management. Staff in-service education sessions are provided and staff are supported to attend external education, as appropriate. Individual education records for staff are maintained. There is a policy for determining staffing and skill mix for safe service delivery. The village is using a range of software to support residents.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

There is comprehensive service information available. Initial assessments and risk assessment tools were completed by the registered nurse on admission. Care plans and evaluations were completed by the registered nurses within the required timeframe. Care plans demonstrated service integration, were individualised and evaluated six monthly. Care plans, written evaluations, assessment tools and monitoring forms were completed and updated electronically. Copies of care plans were available for care staff. Residents and family interviewed confirmed they are involved in the care planning and review process. There is an improvement required around documentation of interventions in care plans to reflect the resident’s current health status.

The diversional therapist and activity coordinators provide separate activities programme for rest home, hospital and special care residents. The Engage programme ensures the individual abilities and recreational needs of the resident are met. The programme was varied, interesting and involved the families and community. The service has introduced a pet pampering programme across all three areas which has had a positive effect on attendance, resident wellbeing and satisfaction levels. The service is awarded a continuous improvement for its pet pampering programme.

Staff responsible for medicines administration have completed annual competencies and education. Medication charts meet legislative requirements. The general practitioners complete three monthly medicine reviews.

Meals are prepared on site. The menu was designed by a dietitian and is used throughout Ryman facilities. Individual and special dietary needs are catered for, alternative options are provided. Residents interviewed responded favourably to the meals provided.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 in place that meet the restraint standards. There is a restraint co-ordinator with delegated responsibilities for monitoring enabler/restraint use and compliance of assessment and evaluation processes. Enabler and/or restraint use is discussed at approval committee and clinical meetings. Staff have attended restraint and challenging behaviour education. There were seven residents requiring restraint and three residents using enablers at the time of audit.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The Infection Prevention and Control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six monthly comparative summary is completed. The service has successfully managed to contain an outbreak of norovirus during the period 30 December 2014 to 14 January 2015.

## 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** | 2 | 47 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 2 | 98 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures were being implemented that aligned with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents were provided with information on admission which included the Code. Staff received training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interview with seven care givers (six who work across the care centre and one from the serviced apartments), four registered nurses, and one enrolled nurse demonstrated an understanding of the Code. Residents interviewed (three rest home and seven hospital) and relatives (two special care) confirmed that staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes were discussed with residents and families on admission. Written specific consents were evident in resident files sampled (four hospital, three rest home and three dementia care). Caregivers (seven) and registered nurses (four) interviewed confirmed consent is obtained when delivering cares. Resuscitation orders for competent residents were appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident was deemed incompetent to make a decision. Discussion with family members identifies that the service actively involves them in decisions that affect their relative’s lives. Ten admission agreements sighted were signed within the required timeframe.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files includes information on residents’ family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents were assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | There is a documented complaints management procedure in place. The organisational complaints policy was being implemented. The village manager has overall responsible for ensuring all complaints are fully documented and investigated. A complaints register is maintained that included relevant information. Documentation was available. The number of complaints received each month were reported monthly to staff via the various meetings. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Feedback forms were available for residents/relatives in various places around the facility. A complaints procedure was provided to residents within the information pack at entry. There is one matter related to a sudden death of a resident that is currently open with the Coronial office and is awaiting a hearing date. The matter that was being addressed with the DHB regarding room charges at the previous audit has been closed. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | There is an information pack that includes information about the Code and the nationwide advocacy service. There is also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The village manager described discussing the information pack with residents/relatives on admission. 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. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. An annual resident satisfaction survey had been completed in July 2014 and the results showed the overall resident experience was reported as being good or very good by 95% of respondents. A survey of relatives conducted in October 2014 showed that Julia Wallace was ranked the second highest performer nationally out of 23 villages The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this included family involvement. Interviews with residents confirmed their values and beliefs were considered. There is instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.Interview with caregivers described how choice is incorporated into resident cares.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. | FA | Ryman has a Maori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that 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 reported there were no residents that identified as Maori.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | An initial care planning meeting is carried out where the resident and/or whanau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed that residents’ values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provides guidelines and mentoring for specific situations. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries in respect of gifts. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | CI | All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently 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.A range of clinical indicator data are collected against each the service level, and reported through to head office for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman Accreditation Programme (RAP). Quality Improvement Plans (QIP) are developed where results do not meet expectations. VCare Kiosk is the electronic patient system used by all sites to report relevant data through to head office. The system of data analysis and trend reporting is designed to inform staff at facility level. Management at facility level are then able to implement changes to practice based on the evidence provided. As a result of this programme management at Julia Wallace identified that the number of residents experiencing skin tears was high in January 2014. They then introduced a quality improvement initiative designed to improve practice, which they hoped would directly reduce the rates of skin tears in the resident population at the village, which as outlined below proved successful. They also introduced a pet pampering programme (link 1.3.7) within the activities programme to improve attendance, resident and relative satisfaction and to calm residents who exhibited challenging behaviours, which was also successful. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents within VCare Kiosk. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The governing body, Ryman Healthcare Limited, has established systems in place that define the purpose, values, scope, direction and goals of the organisation and the facility, and the monitoring and reporting processes against these systems. The service provides rest home and hospital level care for up to 104 residents. Twenty serviced apartments have previously been certified as suitable to provide rest home level care. There were 94 residents in the facility on the day of audit including 30 rest home level residents (10 of which were living in a serviced apartment), 41 hospital level residents and 20 residents receiving specialist dementia services. There was a contracted physiotherapist that provided eight hours of physiotherapy a week and two physiotherapy aids who shared a part-time role from Monday to Friday. A general practitioner (GP) provided on-site contracted medical services and other residents received GP services from other general practitioners. Ryman Healthcare has an organisational total quality management plan in place. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the RAP. Julia Wallace was in the process of confirming its 2015 objectives at the time of audit. There has been a change in village manager and clinical manager since the previous certification audit. The village manager commenced employment May 2013. She is a qualified medical microbiologist and haematologist with previous management experience. She is supported by a clinical manager who is a registered nurse with a current practising certificate. The clinical manager commenced in the role in January 2013. The clinical manager has been previously employed as a manager in a DHB and in aged care. They are both supported by an assistant manager who assists with administration matters including rostering. The hospital, rest home and special care (i.e., dementia) services are managed by registered nurse coordinators, which is a change that was implemented in late 2013. The serviced apartments are coordinated by an enrolled nurse.The management team is supported by the wider Ryman management team which includes support from a regional manager. The village manager and clinical manager have maintained at least eight hours to date of professional development activities related to managing a village.  |
| Standard 1.2.2: Service Management 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.  | FA | The daily operation of the village is led by the village manager in consultation with the clinical manager. Each area has its own dedicated coordinator. The rest home, hospital and special care unit are managed by coordinators who are registered nurses and the serviced apartments are managed by a coordinator who is an enrolled nurse. Clinical care is overseen by the clinical manager who reports to the village manager. The village is supported by a regional manager. If the village manager is absent for an extended period then the village is managed by the clinical manager with assistance from the assistant manager. Depending on the circumstances, Ryman may appoint a temporary relief village manager. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service was implementing the Ryman Accreditation Programme (RAP) which links key components of the quality management system to village operations. Staff interviewed understood the quality programme and the programme was being implemented. The RAP Committee meet monthly. Outcomes from the RAP Committee are reported across the various meetings including the full facility, registered nurse and caregivers. Meeting minutes include discussion about the key components of the quality programme. Policy review is coordinated by Ryman head office and occurs at least three yearly in line with the document control policy. 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. Facilities have a master copy of all policies and procedures and the related 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 be completed to maintain competence. The surveys have been completed by the various staff groups. The RAP prescribes the annual internal audit schedule that was being implemented. Audit summaries and QIPs are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee (eg, RAP, health and safety). Monthly clinical indicator data are collated across the all areas. There is evidence of trending of clinical data and development of quality improvement plans when results do not meet expectations. The quality system includes the monitoring of adverse events, consumer complaints, infection prevention and control, health and safety and restraint management. The combined health and safety and infection prevention and control committee met bimonthly and include discussion of all incidents/accidents and infections. There was a current hazard register in place. Management report progress against the quality and risk management plan and quality improvement initiatives at least monthly to head office staff. |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | All adverse events are documented and reported to head office using the VCare Kiosk system. These events are initially recorded on hard copy forms and a copy of the form is filed in the resident’s hard copy clinical record once the data is entered into VCare Kiosk. Electronic and hard copy incidents were reviewed and all had been completed with appropriate clinical follow up. Monthly analysis of incidents by type was undertaken by the service and reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Quality improvements plans (QIPs) have been created when the number of incidents exceeded expectations (eg, skin tears). 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 (eg Health Protection Public Health MidCentral DHB and Ryman head office were informed of the recent Norovirus outbreak).  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Human resource practice is overseen by head office staff with the village manager managing most of the onsite requirements with support from the clinical manager and assistant manager. There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are also job descriptions for all roles. Appropriate recruitment documentation was seen in the staff files reviewed. A register of practising certificates is maintained. Performance appraisals are current in all files reviewed. The workforce turnover is considered stable. Staff interviewed believed that management were supportive and responsive to their requests. All staff interviewed spoke positively about their orientation, induction and ongoing access to educational opportunities.There is an annual training plan in place which was aligned with the RAP. There is a registered nurse who oversees caregivers’ participation in the ACE programme. Of the caregivers, the majority had completed ACE Foundation or equivalent and 13 were in progress of completing; 34 had completed ACE Core training and 15 had completed ACE Advanced training and all of these 15 caregivers were assessed as competent to administer medicines. Of the 16 caregivers regularly employed in the special care unit 14 of 16 had completed ACE dementia training with two of the 16 being in training. Ryman ensures its registered nurses (RN) are supported to maintain their professional competency. There is an RN journal club that meets two monthly. Ryman has a 'Duty Leadership' training initiative that all registered and enrolled nurses and senior leaders complete. There is an induction programme being implemented with completion being monitored and reported monthly to head office as part of the RAP programme. The registered nurse who oversees the ACE programme maintains a database of staff who have attended educational opportunities. The database is used for planning of ongoing education in conjunction with the performance appraisal system. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a fulltime clinical manager. The rest home, hospital and special care unit have their own dedicated registered nurse coordinators and an enrolled nurse coordinates the serviced apartments. All coordinators work fulltime. There is at least one registered nurse and first aid trained member of staff on every shift. Interviews with caregivers regarding the roster operated in each area confirmed that there areas were staffed in keeping with industry and contractual standards. Caregivers reported there are sufficient staff on duty at all times. Interviews with residents and relatives also indicated there are sufficient staff to meet resident needs.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard in all areas or on the electronic patient management system (VCare Kiosk). Care plans and notes were legible and where necessary signed (and dated) by staff including designation. Individual resident files demonstrated service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.  |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The village manager screens all potential residents prior to entry to services. The clinical manager ensures the service can meet the potential residents assessed level of care. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the village manager. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on: minimising restraint, behaviour management and complaints. The admission agreement reviewed aligns with a) -k) of the ARC contract. Ten admission agreements sighted had been signed. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Three resident files reviewed in the special care (dementia) unit included a needs assessment determining the resident required specialist dementia care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Transfer information was 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. RNs interviewed could describe the required transfer documentation including the district health board transfer form and pink envelope system. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All medication is managed appropriately in line with required guidelines and legislation. RNs, enrolled nurse and senior caregivers responsible for the administering of medication complete annual medication competencies and attend annual medication education. The service uses individualised medication blister packs for medications. Medications are checked on delivery against the medication chart. Medication trolley contents were all within expiry dates and all eye drops were dated on opening. Emergency oxygen and suction is available. Self-medication assessment and reviews have been completed as per policy for one resident self-administering their medicines. Standing orders are not in use. Medication administration practice observed in the special care unit was appropriate. ‘As required’ medications have the date and time of administration on the signing sheet. Twenty medication charts sampled (eight hospital, six rest home and six dementia care) meet legislative prescribing requirements. All 20 medication charts reviewed identified three monthly medication reviews signed by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service employs a qualified cook daily who is supported by a cook assistant, kitchen hand and tea person each day. There is a four weekly seasonal menu that had 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 weight loss/weight gain or swallowing difficulties. Dietary requirements such as vegetarian, gluten free and lactose free diets were accommodated. Food is delivered in hot boxes to the special care, hospital and serviced apartments. Meals are served from bain maries by staff. Each area has a list of resident likes and dislikes. Staff were observed sitting with the residents and assisting them with meals as required. The service is well equipped. The fridge and freezer temperatures are recorded monthly. Food temperatures are monitored twice daily and recorded. All foods were date labelled in the pantry and chiller. A cleaning schedule is maintained. Chemicals are stored safely. Residents and families interviewed commented positively on the meals. Staff have been trained in safe food handling and chemical safety. Nutritious snacks are available 24 hours a day for residents including those living in the dementia care unit. “Food on the Run” platters are delivered three times a day to the special care unit.  |
| Standard 1.3.2: Declining Referral/Entry To Services 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.  | FA | The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry would be referred back to the Needs Assessors or referring agency for appropriate placement and advice.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with resident and relative. Risk assessment tools were sighted as completed (on the VCare system) and these had been reviewed at least six monthly or when there was a change to a resident’s health condition. Care plans reflected the outcome of the risk assessments (link 1.3.6.1- pain assessments). Dementia resident files sampled included an individual assessment that included identifying diversional, motivation and recreational requirements. Challenging behaviours assessments have been completed where appropriate and behaviour management plans were in place. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long term care plan includes nursing diagnosis, actual or potential/deficits outlined objectives of nursing care and overall described the support required to meet resident goals (link 1.3.6.1). The long term care plan identifies allied health involvement. Resident/family/whanau involvement in the care planning and review process was evidenced by signatures on the written acknowledgment of care plan form in the resident files sampled. Short term care plans were in use for changes in health status (link 1.3.6.1). Resident files reviewed for residents receiving special care services identified current abilities, level of independence, identified needs and specific behavioural management strategies. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Residents interviewed reported their needs were being met. Relatives interviewed stated their relative’s needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultation. Faxes to the GPs for residents change in health status were sighted in the resident’s files. Shortfalls were identified in hospital and dementia files reviewed.Dressing supplies were sighted and treatment rooms were adequately stocked for use. VCare wound assessments, wound treatment and evaluations have been completed for skin tears, chronic wounds and two pressure areas (one rest home and one hospital). The GP and wound nurse were involved in the management of residents who had chronic wounds. The facility has a wound champion nurse. Continence products were available and resident files include a three day urinary continence assessment (where applicable), bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager interviewed. Monitoring forms in place included (but were not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts |
| Standard 1.3.7: Planned ActivitiesWhere 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. | CI | A team of two diversional therapists (DTs), and activity coordinator and activity assistant implement separate activity programmes for the rest home, hospital and dementia care units. An activity assistant is employed three afternoons a week to ensure the rest home residents in the serviced apartments receive individual recreation time and are encouraged to participate in the serviced apartment or rest home programme. The Engage programme is delivered Monday to Sunday in the hospital and dementia care units and Monday to Friday in the rest home. Specific activities are required to be included in the Engage programme. Other activities included are as a result of resident feedback through meetings and surveys. The activity co-ordinators are trained to deliver the Triple A exercise programme, which is applicable to the cognitive and physical abilities of the resident group. Activities in each unit includes entertainers, outings, church services and community visitors. The resident/family/whanau as appropriate complete a “Life experiences” information sheet. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. The activity plans were reviewed at the same time as the clinical care plans in resident files sampled.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The written evaluation template describes progress against every goal and need identified in the care plan. Short term care plans are utilised and evaluated regularly (link 1.3.6.1). Family were invited to attend the multidisciplinary review (MDR) meetings. The physiotherapist, GP, activity co-ordinator and care staff were involved in MDR meetings. Care plans reviewed were evaluated six monthly or more frequently when clinically indicated. All initial care plans sighted had been evaluated by the RN within three weeks of admission.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager interviewed stated that nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals were made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed. A resident in the special care unit had been reassessed and transferred to the rest home as their condition had improved.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets are available.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 9 December 2015. The facility has two levels with the care centre (rest home and hospital) on the ground level and dementia care unit and serviced apartments on the first floor. There is lift and stair access between the levels. The full-time maintenance person addresses maintenance requests and maintains a 12 monthly planned maintenance schedule. Annual calibration and functional checks of medical equipment was completed in October 2014. The service has a trained electrical tester (maintenance) and equipment to carry out electrical testing. Hot water temperatures in resident areas are monitored quarterly and were recorded as stable between 43-45 degrees Celsius. Contractors are continuously available for essential services. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. The service employs grounds and garden staff that maintain the external areas. Residents were observed to safely access the outdoor gardens and courtyards safely. Seating and shade is provided. There were no residents who smoked. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | All resident rooms in the units are single and have ensuites. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy is assured when staff were undertaking personal cares |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each unit had an open plan lounge and dining area. There are seating alcoves and family rooms available for quiet private time or visitors. The communal areas are easily and safely accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the RAP programme. 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 for the laundry. There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they are happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing is treated with care and returned to them in a timely manner. The implementation of a laundry labeller has reduced the amount of missing items of clothing and is increasing resident and relative satisfaction.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The Village has an approved fire evacuation plan and fire dills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (two gas BBQs) available in the event of a power failure and Ryman has an arrangement in place for supply of an emergency generator. Emergency lighting is in place which will last for four hours. There are civil defence kits in the facility and stored drinkable and non-drinkable water on site. Electronic call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night and there is external security in place. The service utilises security cameras and an intercom system. There are cameras in the hallways in the secure unit to promote resident safety. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight |
| Standard 3.1: Infection control managementThere 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.  | FA | The infection prevention and control programme is appropriate for the size and complexity of the service. There is an infection prevention and control responsibility policy that includes a chain of responsibility and an infection prevention and control officer’s job description. The infection prevention and control programme is linked into the quality management system via the RAP. The infection prevention and control committee is combined with the health and safety committee which meets bimonthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the RAP annual calendar. The facility has developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control committee (combined with the health and safety 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 (who is the infection prevention and control officer); and maintenance. The facility also has access to an infection prevention and control nurse specialist, public health, GP's and expertise from within the organisation. |
| Standard 3.3: Policies and proceduresDocumented 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 is comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman. The infection prevention and control policies link to other documentation and cross reference where appropriate.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The infection prevention and control officer (i.e., the clinical manager) has appropriate training for the role. The induction package included specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections is in place appropriate to the complexity of service provided. Individual infection report forms have been completed for all infections and kept as part of the resident files. Infections have been included on a register and a monthly report has been completed by the infection prevention and control officer. Monthly data has been reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme is linked with the RAP. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There was a recent outbreak of Norovirus, which lasted from 30 December 2014 to 14 January 2015 and affected a number of residents and staff. The outbreak was appropriately managed and reported. The facility was thanked by MidCentral Public Health Service for successfully containing the illness within the facility. The infection prevention and control officer has documented the event and has held a debriefing session with staff. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The policy identifies that restraint is used as a last resort. The service had seven residents using restraints (i.e., five chair briefs and two bedrails) and three residents using enablers on the day of audit. Resident files sampled using enablers identified that consents were voluntarily signed by the resident. The restraint approval committee reviews the use of enablers six monthly. Enablers were documented on the long term care plans reviewed of those utilising enablers.  |
| Standard 2.2.1: Restraint approval and processesServices 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.  | FA | The restraint coordinator is the hospital coordinator who is a registered nurse. The restraint coordinator has been in the role for four years. The overall responsibility for restraint is included in the hospital coordinator’s job description. There is a restraint approval committee that meets six monthly. Approved restraints are documented in the restraint policy. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraints are included in care staff orientation and education is on-going. Restraint use is discussed at caregiver and RN meetings. The restraint coordinator has completed a post graduate paper in 2013 that included challenging behaviours and has completed the Ryman restraint induction last 2014 as a refresher.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments are undertaken by the restraint coordinator 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. A restraint assessment and consent form is completed in consultation and discussion with the resident/family/whanau and GP. Resident files reviewed evidenced a restraint risk assessment, consent form and three monthly evaluations. All completed assessments considered the factors listed 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | Monitoring and observation process is included in the restraint minimisation policy. There is a specific restraint section of the overall resident VCare care plan that includes interventions and care required during episodes of restraint. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised. Alternative strategies were documented on the behaviour charts of residents with challenging behaviour. A restraint register is in place. Monitoring forms include regular monitoring and cares provided.  |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Three monthly reviews are completed as evidenced in the files reviewed of three residents with restraint. Written evaluations are also completed by the restraint co-ordinator/RN 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 approval committee. Individual restraint use is monitored and recorded by care staff. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices 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 coordinator. An annual restraint audit was conducted. Relevant incident/accidents were reviewed by the restraint coordinator. Corrective actions are monitored. Issues/concerns were discussed at the meetings (minutes sighted). Restraint use is linked to the Ryman Accreditation programme (RAP).  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultation. Faxes to the GPs for residents change in health status were sighted in the resident files reviewed.  | 1)The following intervention shortfalls were identified in two of four hospital files reviewed; (i) Resident A - changes to mobility, pressure area and pain status had not been updated on the long term care plan as per written evaluation. There was no pain assessment for new knee pain and (ii) Resident B - there was no short term care plan for bilateral leg cellulitis or pain assessment for leg pain. The care plan did not reflect management of weight gain as per the medical notes. 2)The following intervention shortfalls were identified in two of two dementia files reviewed; (i) Resident A - continuing weight loss as per the written evaluation and (ii) osteoarthritis and reported hip pain.  | Ensure interventions are documented to reflect the resident’s current health status. 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The new village manager and clinical manager identified in February 2014 that a high level of residents were experiencing skin tears at the facility which they believed could be improved by an improvement in practice standards. In January 2014 there were a total of 22 residents who had skin tears, the majority of whom (i.e., 17) were receiving hospital level care. Management then focused on determining the root cause of each skin tear between February and April. They were unable to determine a direct link between the number of skin tears to any particular area, or to a time of day or to any particular staffing situation. There was no particular pattern to the data. They decided in consultation with the facility physiotherapist that the transfer procedure for staff transferring residents could be further improved. Implementing best practice would then minimise the risk of residents sustaining skin tears during transfer procedures. An in-house training programme was strengthened to further improve the manual handling techniques of all care staff in June 2014 Two training sessions were held and it was determined by results of skin tears in the resident population that this approach was still insufficient. It was decided to implement a compulsory annual manual handling competency for all staff that provided care including activities staff. The training is provided by the physiotherapist in small group sessions of around three staff and the focus is on correct manual handling technique. Newly appointed staff have always had manual handling training but now they have individual training given by the physiotherapist within the first two weeks of their employment to ensure their technique is correct. All staff lift residents in pairs and having two trained staff working together ensures that each staff member can correct their colleague if necessary. Management decided against using prompt sheets for transferring which are typically displayed in each resident’s room in favour of a focus on correct technique. In addition to the focus on correct technique residents at risk of skin tears due to fragile skin also wear arm and leg protectors. The number of residents who sustained skin tears in 2014 has reduced as follows: 56 in the January to March period; 42 in April to June; 32 in July to September, 6 in October to December 2014 and 1 in January 2015. Management attribute the gains directly to an a) the increased focus on skin tears by management, b) the increased focus on best practice and the application of correct lifting technique by all care staff and c) the implementation of annual competency testing. Staff turnover is not considered to be a contributing factor to the improvement in results. The quality initiative also benefits care staff and Ryman by ensuring that the injury risk to care staff is minimised.  | The new management team determined that the level of residents sustaining skin tears in the resident population was unacceptably high in January 2014 and identified this as a quality improvement initiative. Following a two month period of research into the root cause of each resident who subsequently sustained a skin tear, and finding no one probable cause, management decided in May 2014 to focus on ensuring that the correct transfer technique was being practised consistently by care staff. A training programme was implemented in June and revised in October. In October the training programme was changed to ensure that all care staff including activities staff completed a compulsory annual manual handling course and that all staff attending this course were required to demonstrate competency in safe patient handling technique. This focus on best practice has resulted in a significant reduction in the number of residents sustaining skin tears in the last quarter of 2014 (i.e., 6 compared to 56 for the first quarter of 2014). |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The Engage programme, which is a Ryman initiative, has been in place for three months at Julia Wallace. The activity team (interviewed) stated there is more activities happening in the resident’s day as a result of separate engage programmes for each unit. Each unit has separate entertainers, theme/events and celebrations. This allows for more space in the lounges when entertainment is held and the activity is more designed to meet the consumer group’s cognitive and physical abilities. Residents in the special care unit are able to enjoy entertainment within their own environment reducing anxiety and distress from being with a larger group.  | The new management team and the new activities team identified in late 2013 that there was a poor uptake of residents involved in the group activities programme across all areas and that there was general discontent with the activities programme amongst residents and their families. Staff are aware that interaction with pets was both an enjoyable experience for residents and was known to have a calming effect on behaviour for residents receiving specialist dementia services. The diversional therapy team accepted the challenge of finding ways to introduce pet pampering (therapy) safely within the facility. A local pet shop was engaged to operate a pet pampering programme at the facility. The manager of the pet shop now brings a wide range of pets to the facility for two hours on a weekly basis. The pet pampering programme includes a visit to each lounge area. Each resident in the lounge is then offered the choice of holding or playing with their choice of pet. Pets include kittens, cats, large dogs, small (toy) dogs, puppies, baby chicks, rabbits, guinea pigs, an Australian lizard, alpacas and turtles. Most residents and relatives appreciate the opportunity to interact with the animals. Attendance numbers in the group activities programme have increased especially when pet pampering occurs. Staff have noticed a decrease in incidents of residents exhibiting challenging behaviours in the specialist dementia unit (i.e., from 93% (January to June 2014) to 57% (July to December 2014) which they directly attribute to the introduction of the pet therapy and its calming effects. There has been an increase in resident/relative satisfaction results. The village was ranked 14 out of 25 in January 2014 for relative satisfaction and in October 2014 was ranked the second most satisfied out of all 23 Ryman villages. Resident satisfaction was last analysed in July 2014 and the village ranked 11th of 24 villages. Management believe that the introduction of the pet pampering programme has contributed positively across a number of data indicators. |

End of the report.