# Hilda Ross 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:** Hilda Ross Retirement Village Limited

**Premises audited:** Hilda Ross 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: 1 April 2015 End date: 2 April 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:** 147

# 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

Hilda Ross Village is a Ryman Healthcare facility. The facility provides rest home, hospital and dementia level of care for up to 151 residents. On the day of audit there were 147 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.

The village manager is suitably qualified and supported by a clinical manager (registered nurse) and an assistant village manager. There is structured systems in place that provide support and guide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. An induction and in-service training programme is being implemented that provides staff with appropriate knowledge and skills to deliver care.

This audit identified improvements required around care plan documentation and interventions. The service has been awarded a continuous improvement (CI) around the implementation of the Engage programme.

## Consumer rights

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

Hilda Ross provides care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessments have been undertaken on admission and during the review process. Policies were being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was readily available to residents and families. Care plans accommodated the choices of residents and/or their family. Informed consent has been sought and advanced directives were appropriately recorded. Complaint processes were being implemented and complaints and concerns were managed and documented. Residents and family interviewed verified on-going involvement with the community.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Hilda Ross was implementing the Ryman Accreditation Programme that provides the framework for quality and risk management. Key components of the quality management system linked to a number of meetings including staff meetings. An annual resident/relative satisfaction survey was completed and there were regular resident/relative meetings. Quality and risk performance was reported across the various facility meetings and to the organisation's management team. Hilda Ross provided clinical indicator data for the three services being provided (hospital, rest home and dementia care). There were human resources policies including recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provided new staff with relevant information for safe work practice. There was an in-service training programme covering relevant aspects of care and support and external training was supported. The organisational staffing policy aligned with contractual requirements and included skill mixes.

## Continuum of service delivery

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

There was 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 on the on-line system. Copies of care plans were available for care staff. The residents and family interviewed confirmed they were involved in the care planning and review process. Short term care plans were in use for changes in health status. The activity coordinators provide a separate activities programme for rest home and hospital residents. The Engage programme ensures the individual abilities and recreational needs of the resident are met. It was varied, interesting and involves the families and community.

Staff responsible for medication administration have completed annual competencies and education. There were three monthly GP medication reviews. Meals were prepared on site.

The menu was designed by a dietitian at organisational level. Individual and special dietary needs were catered for. Alternative options were provided. Additional desserts were provided in the hospital unit for weight management. Residents interviewed responded favourably to the meals provided.

## Safe and appropriate environment

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

The building has a current warrant of fitness. There was a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms were single and have ensuites. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. The service has an approved fire evacuation scheme. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Housekeeping staff maintain a clean and tidy environment. All laundry and linen was completed on-site.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager/restraint officer oversees restraint/enabler usage within the facility. The service currently has four residents using a restraint and two residents voluntarily using enablers. A register for restraints and enablers is maintained. Review of restraint use was reviewed by the restraint approval committee. Staff were trained in restraint minimisation.

## 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 control programme was appropriate for the size and complexity of the service. The infection control officer (clinical manager) was responsible for coordinating/providing education and training for staff. The infection control officer had attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer used the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engaged 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** | 1 | 47 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 1 | 98 | 0 | 1 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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 Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families (four hospital, three dementia care unit and one rest home) and residents (five rest home and three hospital) interviewed stated they were provided with information on admission which included the Code. Interview with seven care assistants (who work across the care centre) demonstrated an understanding of the Code. Residents and relatives confirm staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed Consent  Consumers 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 are discussed with residents and families on admission. Written general and specific consents were evident in the resident files sampled (five hospital, four rest home and four dementia care). Care assistants and RNs interviewed confirm 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 is 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. Thirteen admission agreements sighted were signed within the required timeframe. |
| Standard 1.1.11: Advocacy And Support  Service 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 Resources  Consumers 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. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative 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 | The organisational complaints policy is being implemented at Hilda Ross. The village manager has overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. Each service level has its own up to date complaints register. Concerns and complaints are discussed at relevant meetings. One complaint remains open and is being managed appropriately. Advocacy service has been accessed with ongoing communication between the service and complainant. One coroner case remains open.  Discussion residents and relatives confirmed they were provided with information on the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack that includes information about the Code. There was also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives informed information had been provided around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The village manager reported having an open door policy and 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 Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Ryman has policies that support resident privacy and confidentiality. A tour of Hilda Ross 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. 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 with family involvement (13 files reviewed). There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.  Interview with seven care assistants described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | 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 identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers 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 inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, clinical services manager, unit coordinator and five registered nurses (RN) confirmed an awareness of professional boundaries. Care assistants interviewed could discuss professional boundaries in respect of gifts. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | All Ryman facilities have a master copy of policies which have been developed in line with current accepted best and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Each unit has staff meetings and resource folders for staff. There are written and verbal handovers between shifts. Staff complete competencies relevant to their role. An annual in-service education programme planned by the Ryman Accreditation programme (RAP) and this is being implemented at Hilda Ross. Registered nurses reported having access to external training and on-going training through the journal club.  Services are provided at Hilda Ross that adhere to the Health & Disability Services Standards. |
| Standard 1.1.9: Communication  Service 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. Hilda Ross enters incidents into the Ryman VCare system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed on the VCare system met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. Resident and relative meetings are held regularly. A consumer liaison person at head office contacts resident six weeks post admission to discuss their admission experience.  There was an interpreter policy and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Hilda Ross is a Ryman Healthcare retirement village. The service provides rest home, hospital level and dementia level of care for up to 151 residents in the care centre. Twenty serviced apartments have been certified as suitable to provide rest home level care. There were 147 residents in the facility on the day of audit including 53 rest home, 50 hospital level residents and 39 dementia care residents. There are five rest home residents in serviced apartments.  Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Hilda Ross objectives for 2015 include: enjoyment of Engage programme, individualised care through VCare kiosk system, workplace safety practices and staff team building.  The village manager at Hilda Ross has been in the role for two years and was the assistant manager previously. She has had 13 years’ experience in aged care with Ryman. The clinical manager/RN has been in the role four months and has completed the RN orientation and induction. She is supported by RN unit coordinators in each area and clinical advisors at head office. Management are supported by a regional manager and clinical quality auditor (at head office).  The village manager has maintained at least eight hours annually 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 | Ryman policy outlines manager availability including on call requirements. During a temporary absence, the assistant manager and clinical manager cover the manager’s role. The assistant manager covers administrative functions and clinical manager clinical care. The regional manager provides oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Hilda Ross is implementing the RAP which links key components of the quality management system to village operations. There are full facility RAP meetings monthly.  Outcomes from the RAP Committee are reported across the various meetings including those for full facility, registered nurse and care assistants. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Health and safety and infection control meetings are held three monthly. Clinical meeting minutes were sighted. Interview with staff confirmed an understanding of the quality programme.  Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. 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.  A relative survey was last completed May 2014. Results have been collated. Areas of concern were identified and quality improvement plans raised (QIPs) and completed.  The RAP prescribes the annual internal audit schedule that has been implemented at Hilda Ross. Audit summaries and QIPs are completed where a noncompliance is identified (<90%). Issues and outcomes are reported to the appropriate committee e.g. RAP, health and safety. QIPs reviewed are seen to have been closed out once resolved.  Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets – e.g. falls. Falls prevention strategies are in place that include: hi/lo beds, on-going falls assessment and exercises by the physiotherapist, sensor mats, fall prevention pamphlets and appropriate footwear. A footwear supplier visits the care centre regularly. The service has a “lounge assistant” in the afternoons in the hospital unit to monitor high falls risk residents.  Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Quality objectives for the 2014 year have been reviewed and 2015 objectives in place  There is a health and safety, and risk management programme being implemented at Hilda Ross. The combined health and safety and infection control committee meet three monthly and include discussion of incidents/accidents and infections. There is a safety representative who has attended training. There is a current hazard register. |
| 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 | Hilda Ross collects incident and accident data and completes electronic recording of events. Monthly analysis of incidents by type is undertaken by the service and reported to the various staff meetings. Data links to the organisation’s benchmarking programme and is used for comparative purposes. QIPs have been created when the number of incidents exceeded the benchmark. 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. |
| 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 | There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are job descriptions for RAP officers. Appropriate recruitment documentation was seen in the 14 staff files reviewed. Performance appraisals are current in all files reviewed. Interview with care assistants and RNs inform management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation.  There is an annual training plan aligned with the RAP that was being implemented. The aged care education assessor (employed three days a week) is currently on leave and the staff have access to the roving assessor from head office in the interim. The service has introduced on-line learning which has improved the number of staff participating in mandatory training.  Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings and completing InterRAI training through the Ryman programme. A register of current practicing certificates is maintained.  Ten of 23 care staff who are employed in the dementia care unit have completed their dementia specific units. The remaining 13 staff have commenced dementia specific units within the required timeframe. |
| 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. Each unit in the care centre has a RN Unit coordinator. The serviced apartment coordinator is an enrolled nurse. There is at least one registered nurse on duty 24/7. Interviews with care staff informed the registered nurses are supportive and approachable. Interviews with residents and relatives indicated there are generally 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 were 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. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. |
| 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 hascomprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The clinical manager screens all potential residents prior to entry to services to confirm they meet the level of care provided at the facility. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager.  E4.1.b There is written information on the service philosophy and practices particular to the Unit including:  1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract. Thirteen admission agreements sighted had all been signed within the required timeframe. E3.1 Four files reviewed include a needs assessment as requiring specialist dementia cares. |
| 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 is completed by the registered nurse or clinical manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. RNs interviewed could describe the required transfer documentation. Relatives interviewed confirmed they are 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 and caregivers responsible for the administering of medication complete annual medication competencies and attend annual medication education. The service uses individualised medication blister packs for regular and PRN 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. There were two self-medicating residents who were monitored every shift as per policy. Medication administration practice was observed to be compliant. As required medications have the date and time of administration on the signing sheet. Twenty six medication charts sampled (10 hospital, eight rest home, eight special care unit) meet legislative prescribing requirements. The 26 medication charts reviewed identified three monthly medication reviews signed by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service employs qualified cooks seven days a week. They are supported by a kitchen assistant 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 was notified of dietary changes following the six monthly review and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Food is delivered in hot boxes to each area and served from bain maries. Staff were observed sitting with the residents when assisting them with meals. The service is well equipped. The fridge, freezer and chiller temperatures are checked daily. Food temperatures are monitored twice daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service was received from resident and staff meetings, surveys and audits. Staff have been trained in safe food handling and chemical safety. Snacks and additional food are available 24 hours a day. |
| 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 right to appeal against assessment outcome policy states the manager at every stage will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry was 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. Risk assessment tools were sighted in resident files (#link 1.3.6. 1). Assessments are reviewed at least six monthly or when there is a change to a resident’s health condition.  E4.2; Four dementia resident files reviewed included an individual assessment (specific dementia needs) that included identifying diversional, motivation and recreational requirements.  E4.2a: Challenging behaviour charts and a behaviour analysis tool are completed where required, and as a result de-escalation strategies have been included in the long term care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation however there is an improvement required to ensure care plans reflect the residents’ current needs. There was documented evidence of resident/family/whanau involvement in the care planning process in the resident files sampled. Residents and relatives interviewed confirmed they were involved in the care planning process. Short term care plans were in use for changes in health status (#link 1.3.6.1). |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | 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. Faxes to the GPs for residents change in health status were sighted in the resident’s files.  Dressing supplies are available and treatment rooms sighted were adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency for nine pressure areas (one grade 4, two grade 3, one grade 2, and five grade 1) and two chronic wounds were linked to the long term care plans. Pressure area cares and interventions were documented in the long term care plans. The RNs interviewed have access to external wound specialist as required. The GP reviews the wounds three monthly or earlier if required.  Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.  Monitoring forms in place include (but 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 Activities  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. | CI | There are six activity coordinators at Hilda Ross who provide a separate activity programme for the rest home, hospital, special care unit and serviced apartments. Three 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. Residents in the village apartments are involved in the activities programme. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group.  The resident is assessed 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. 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.  Residents are encouraged to maintain links with the community and community groups visit. Church services are held weekly. There are regular outings and scenic drives for residents in all units. Residents in the special 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 AAA attendance sheets being forwarded to head office. The Engage programme has increased resident participation significantly. A men’s group has been started in the special care unit twice a month, a simulated bar has been set up and male residents have enjoyed reminiscing over an “after work drink”, one resident who is a continuous pacer sits for a full hour in these men’s group sessions. Resident meetings and surveys provide feedback on the activities programme. All residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Village residents are encouraged to be involved in the activities in the care centre and many help as volunteers. |
| 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 were utilised and evaluated regularly. Family are invited to attend the multidisciplinary review (MDR) meetings. The physiotherapist, GP, activity co-ordinator and care staff were involved in MDR meetings. Care plans are 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 and RNs interviewed state they initiate referrals to nurse specialist services. Specialist referrals are made by the GP. Referrals and options for care are discussed with the family as evidenced in interviews and medical notes. Discussions with registered nurses identified that the service has access to appropriate allied health providers. The service provided examples of where a resident’s condition had changed and the resident was reassessed. |
| 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 are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection 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 were 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 8 May 2015.  There is reactive maintenance and planned maintenance. A 12 monthly planned maintenance schedule is in place that includes the calibration of medical equipment and functional testing of electric beds and hoists (June 2014). Hot water temperatures in resident areas are monitored and stable between 43-45 degrees Celsius. Contractors are available 24/7 for essential services. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. The grounds, gardens and external areas are well maintained. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided.  ARC D15.3; The care assistants and registered nurses interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. E3.4d, There are two lounge areas designed so that space and seating arrangements provide for individual and group activities.  E3.3e; There are quiet, low stimulus areas and seating alcoves that provide privacy when required.  E3.3e: E3.4.c; There is a safe and secure outside area that is easy to access for dementia residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms in the units have ensuites. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was 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 single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each unit has a 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. There are two separate dementia care units joined by doors that can be opened up during the day. Activities occur in various locations throughout the facility. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers 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 with the service policies and procedures. 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 were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner. |
| 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. Emergencies and first aid is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Hilda Ross has an approved fire evacuation plan dated 9 May 2014. Fire dills occur six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is available and a backup generator is readily available as required. There are civil defence supplies in the facility and water header tanks. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. |
| 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 management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme is appropriate for the size and complexity of the service. There is an infection control (IC) responsibility policy that included chain of responsibility and an infection control officer job description. The infection control programme is linked into the quality management system via the RAP. The infection control committee meeting is combined with the health and safety committee which meet three monthly. The facility meetings also include a discussion of infection control matters. The IC programme is reviewed annually from head office and directed via the RAP annual calendar. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control committee is made up of a cross section of staff from areas of the service including; (but not limited to) the village manager, the clinical manager (who is the IC officer); RN and kitchen staff member. The facility also has access to an infection control nurse specialist, population health, GP's and expertise within the organisation and access to district health board (DHB) infection control team. The infection control coordinator and unit coordinators have attended external infection control education November 2014. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are comprehensive infection control policies that were are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. Policies and procedures from an external infection control specialist have been implemented. The infection 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 control officer is responsible for coordinating/providing education and training to staff. The infection control officer (clinical manager) has appropriate training for the role. The induction package includes specific training around hand washing and standard precautions and training was provided both at orientation and as part of the annual training schedule. Resident education is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance  Surveillance 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 are in place appropriate to the complexity of service provided. Infections are included on a register and a monthly report is completed by the infection control officer. Monthly data is reported to the combined infection control and health and safety meetings. Staff are informed on infection control matter, trends and quality improvements through the variety of meetings held at the facility. The infection control programme is linked with the RAP. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GPs who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The service has had several outbreaks which have been reported to Population Health. An infection control specialist visited the facility and completed an environmental audit following the outbreaks. A full report was sighted. There were no significant deficits identified. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint policy in place that states the organisation’s philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. On the day of audit there were four residents using restraints and two residents using enablers. Residents using enablers have voluntarily signed a consent form. Assessments are completed and enabler use is reviewed six monthly. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The clinical manager is the restraint officer for the facility and has defined responsibilities included in the job description. The approval committee meets six monthly. There is ongoing education including challenging behaviours. Quality and clinical meetings include discussion on restraint. Staff carry out and record restraint monitoring including cares delivered during the restraint period. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by the registered nurses in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. On-going consultation with the resident and family/whanau was also identified. A restraint assessment form was completed for the four residents requiring restraint (sighted). Assessments consider the requirements as listed in Criterion 2.2.2.1 (a) - (h). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint officer is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation considers the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the on-going reassessment for residents on the restraint register, and as part of their care plan review. Families are included as part of this review where possible. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage throughout the Ryman organisation is monitored regularly. The review of restraint use is discussed at the approval group meetings and relevant facility meetings. The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. The internal restraint audit completed August 2014 achieved 96% result. |

# 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 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Assessments linked to interventions overall in care plans reviewed. Shortfalls were identified around interventions in the four hospital files reviewed. | The care plans for four hospital residents did not reflect the resident’s current level of support for; a) two residents with behaviours, b) one resident with changes to mobility status, and c) resident with medical condition as per GP letter. Caregivers interviewed were aware of current resident needs and therefore the risk has been identified as low. | Ensure care plans reflect current interventions and supports required to meet the individual needs.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Policies and procedures are in place to ensure all residents have appropriate and timely assessments and interventions undertaken. | i) Daily weight, girth measurements and fluid balance have not been completed daily as per care plan for a rest home resident with complex medical problems; ii) There are no documented interventions or GP notification for one hospital resident with a 3.4kg weight loss in one month. iii) One hospital resident with a post fall head injury did not have the falls protocol or neurological observations undertaken as per policy. Time and detail for the residents post fall admission to hospital was not documented in progress notes. There was no GP follow up as instructed in discharge letter. iv) A hospital resident identified as high pressure area risk did not have a pressure area or nutrition assessment undertaken on admission. | Ensure interventions are completed as documented in care plans and medical notes.  60 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 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The Engage activities programme provides activities that are stimulating, varied, meangingful and appropriate to the abilities of the consumer group. | The Engage activities programme was implemented in July 2014 with an aim to increase resident attendance and enjoyment in the activities. The programme was increased to seven days a week in the dementia care unit and hospital unit. There has been a team approach to implementing the programme with staff involvement and support to ensure residents are able to attend activities. Education around the programme has been provided and residents and families kept informed of activities on the Engage calendar and special events. A lounge carer position has been established whose role is to closely supervise residents at risk of falls and coordinate/provide activities on small group or individual basis. The Ryman Triple AAA exercise programme is incorporated into the Engage programme. On the day of audit 27 residents in the special care unit were seen to be enjoying a “fun” Triple AAA session.  Attendance at the Engage activities has increased in all units. Monthly stats have been maintained and show increases as follows: Hospital attendance from 49% in January to 51% in December; dementia care unit 42% in January to 58% in December. Enjoyment of the programme is evaluated through resident meetings and satisfaction surveys. All residents and relatives interviewed were very positive about the Engage programme. Increased attendance at the Engage programme has contributed to a reduction in the number of challenging behaviour incidents in each of the units. From January to July 2014 challenging behaviour incidents made up 65% of all incidents. This dropped to 35% from August to December 2014. Rest home incidents reduced from 60% to 40%; hospital unit incidents reduced from 85% to 15% and dementia care unit incidents reduced from 57% to 43% over one year. |

End of the report.