

Edmund Hillary Retirement Village Limited - Edmund Hillary Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Edmund Hillary Retirement Village Limited
Premises audited:	Edmund Hillary Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 October 2015 End date: 6 October 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:	177



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Edmund Hillary is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 235 residents. On the first day of the audit, there were 177 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

The village manager is appropriately qualified and experienced and is supported by an assistant village manager and a clinical services manager/registered nurse who oversee the care centre. There are quality systems and processes being implemented. The service has been actively working on reducing the incidence of falls, reducing staff turnover and improving communication with service users. The residents and relatives interviewed spoke positively about the care and support provided.

Areas of continuous improvements were identified around good practice, the trending and analyses of quality and risk data, the development and evaluation of corrective action plans and the induction programme for new staff.

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.

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 (HDC) Code of Health and Disability Services Consumers' Rights (eg, 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 ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori 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 complaints, which meets timeframes established by HDC.

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.

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

Services are planned, coordinated, and appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Standards applicable to this service fully attained.
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Care plans and evaluations reviewed were completed by the registered nurses within the required timeframe. Monitoring forms were being utilised. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status.

The activity team provide an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community. There were 24-hour activity plans for residents in the special care unit that were individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Medication is appropriately stored, managed, administered and documented. Meals are prepared on site. The menu is designed by a dietitian at an organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

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.
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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 was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

There are appropriate systems and equipment for emergency management.

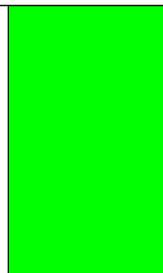
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service currently has two residents assessed as requiring the use of restraint and five residents requiring enablers. The restraint coordinator maintains a register. The restraint coordinator reviews residents using restraints monthly. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme 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 two outbreaks of norovirus during the periods July and September 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	48	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with 12 healthcare assistants (HCAs) who work across each area and all shifts and 18 registered nurses demonstrated an understanding of the Code. Residents interviewed (six rest home and nine hospital residents) and four relatives (one rest home, one hospital and two dementia unit) confirmed that staff respect privacy, and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order (link to CI 1.1.8.1). Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>All 14 resident files sampled (ie, two dementia, six rest home and six hospital) had signed admission</p>

and give informed consent.		agreements and consents.
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 include information on residents' family/whānau 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. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. There is an onsite café and a shop as well, which residents appreciate. Residents are 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	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting timeframes determined by the Health and Disability Commissioner (HDC). Six complaints have been lodged in 2015 (year to date). There is evidence of complaints received being discussed in staff and management meetings. All complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
Standard 1.1.2: Consumer Rights During Service Delivery	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them

<p>Consumers are informed of their rights.</p>		<p>around the Code. Large print posters of the Code and advocacy information are displayed through the facility. The village manager or the assistant village manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>A tour of the premises confirmed there were 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 was completed in February 2015 and the results showed the overall resident experience was reported as being good or very good by 88.6% of respondents. A survey of relatives conducted in March 2015 showed that the village was ranked 10th nationally out of 25 villages for relative satisfaction. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involved residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.</p> <p>Interviews with HCAs described how choice is incorporated into resident care provision.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Ryman has a Māori 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/whānau 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, no residents identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate 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. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed</p>

<p>Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>confirmed that staff take into account their cultural values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. 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 managers, registered nurses and HCAs confirmed an awareness of professional boundaries. HCAs could discuss professional boundaries in respect of gifts.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>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.</p> <p>A range of clinical indicator data is collected against each service level. It is 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. An electronic patient system is 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.</p> <p>Edmund Hillary has implemented a number of process improvements in service delivery resulting in improvements to resident wellbeing. Process improvements have been made in providing access to a medical practice that operates a medical centre on site, in clarifying advanced care planning preferences, in reducing antibiotic resistance, in the practice of restraint minimisation and the reduction of falls.</p>
<p>Standard 1.1.9:</p>	<p>FA</p>	<p>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy which outlines responsibility around open disclosure and communication practices. Staff are required to record</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>family notification when entering an incident into the database. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Edmund Hillary is a Ryman healthcare retirement village. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. It provides rest home, hospital and dementia level care for up to 235 residents. This includes 40 serviced apartments certified to be able to provide rest home level care, 50 rest home level beds, 115 hospital level beds, and 20 dementia level beds. Fifty-two beds are dual purpose. Occupancy during the audit was 70 rest home level residents (including five in the serviced departments), 89 hospital level residents and 18 dementia level residents. The service holds the Aged Related Residential Care (ARRC) contract, respite contract and the Long-Term Chronic Conditions (LTCC) contract. There were seven residents on respite during the audit and none on the LTCC contract.</p> <p>There is a documented service philosophy set at head office that guides quality improvement and risk management in the service. Specific values have been determined for the facility. Organisational objectives for 2015 are defined with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2015 objectives.</p> <p>The village manager at Edmund Hillary has been in the role since 2013 and has a background in retail management. An assistant manager who carries out administrative functions and a clinical services manager (registered nurse) who oversees clinical care support him. The management team is supported by the wider Ryman management team that included a regional manager. The village manager and clinical services manager have maintained at least eight hours of professional development activities related to managing a village.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective</p>	<p>FA</p>	<p>The assistant village manager and clinical services manager are responsible during the temporary absence of the village manager. The clinical coordinators/RNs are responsible for clinical operations during the temporary absence of the clinical services manager/RN.</p>

<p>manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>CI</p>	<p>Edmund Hillary has a well-established quality and risk management system that is directed by head office. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers (village manager, assistant village manager, clinical services manager/RN, clinical audit and practice manager), the GP, and staff (twelve healthcare assistants, eighteen RNs, one health and safety officer, two cooks, three diversional therapists, three activities coordinators, three cleaners, two laundry staff, one maintenance staff) and review of management and staff meeting minutes, demonstrate their involvement in quality and risk activities.</p> <p>Resident meetings are held two monthly in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed annually. Action plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly Ryman accreditation programme (RAP) calendar. They are communicated to staff, evidenced in staff meeting minutes. Recent updates to policies and procedures include procedures around the implementation of InterRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings that also include review of infection control and of incidents. A health and safety officer is appointed who has completed stage two health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice to March 2016. The hazard identification resolution plan is sent to head office and identifies any key hazards that</p>

		<p>are recognized. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified. There were no staff off work from a work-related accident. A particular focus is on manual handling training of staff, which begins during their orientation (link to CI 1.2.7.3).</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Initiatives implemented include routine checks of all residents specific to each resident's needs (intentional rounding), the use of sensor mats, night-lights, proactive and early GP involvement, appointing senior healthcare assistants, and increased staff awareness of residents who are at risk of falling. Physiotherapy assessments and done by a qualified physiotherapist and regular physiotherapy treatments, provided by a physiotherapy assistant.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms for the facility identifies that all are fully completed and include follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify that the following situations would be reported to statutory authorities including infectious diseases; serious accidents; unexpected death; specific situations to the Ministry of Health, and changes in managers. The public health authorities were promptly notified following two recent norovirus outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Sixteen staff files reviewed (eight healthcare assistants, five registered nurses, one quality coordinator/RN, one activities coordinator, one kitchen assistant) included a signed contract, job description relevant to the role the staff member is in, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of registered nurse practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. The time allocated for orientation/induction training has</p>

		<p>been increased to five days.</p> <p>There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Evaluations are completed for all training provided. Registered nurses are supported to maintain their professional competency. Nine registered nurses have completed their InterRAI training, meeting contractual requirements. Staff training records are maintained. There are implemented competencies for registered nurses and healthcare assistants related to specialised procedure or treatment including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. There are a minimum of three registered nurses and eleven healthcare assistants on duty at any time.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack for residents being admitted to the secure dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy.</p>

<p>for services has been identified.</p>		<p>The admission agreement reviewed aligns with the service's contracts. Fourteen admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</p> <p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well-informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack for residents being admitted to the secure dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy.</p> <p>The admission agreement reviewed aligns with the service's contracts. Fourteen admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. One rest home file of a respite resident that had been transferred to hospital acutely was reviewed. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised blister packs for regular and 'as required' (PRN) medications. Medication reconciliation is completed by an RN on delivery of medication and any errors fed back to pharmacy. All medications were securely and appropriately stored on day of audit. There are weekly and six monthly controlled drug checks.</p> <p>All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p> <p>Twenty-eight medication charts were reviewed (twelve rest home [including two residents receiving rest home care in the serviced apartments], twelve hospital and four dementia). The medication profiles reviewed were legible, up to date and reviewed at least three monthly by the GP. All medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. The medication folders include a list</p>

		<p>of specimen signatures.</p> <p>Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role around medicine administration. Standing orders are not used. The GP and RN had assessed seven self-medicating residents (rest home), as competent to self-administer.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p> <p>There is a signed agreement with the pharmacy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service employs a head chef who is supported by another chef and kitchen staff. The head chef is a health and safety representative on the health and safety committee. All staff have been trained in food and chemical safety. A four weekly seasonal menu 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 reviews and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as vegetarian and pureed/soft meals are provided. Food is delivered in scan boxes to each area and served from bain maries. The serving temperature in the bain maries are monitored and recorded daily. The service is well-equipped steam bake, gas and electric cooking. Fridge and freezer temperatures are checked daily. Chilled goods temperature is checked on delivery. Food temperatures are monitored daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident and staff meetings, surveys and audits. The head chef attends resident meetings and has contact with residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The right to appeal against assessment outcome policy states the manager at every stage will inform the resident/family of other options. The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry was referred back to the needs assessors or referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>The facility has embedded the InterRAI assessment protocols within its current documentation. InterRAI initial assessments and assessment summaries were evident in printed format in the files reviewed. Files reviewed</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>across the rest home and hospital and dementia identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour and wound care were appropriately completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans sampled were resident centred and support needs were documented in detail. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect acute changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals. Two respite resident files reviewed included an initial assessment, short-term care plan and regular progress notes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a residents' condition alters, the registered nurse initiates a review and if required a GP visit. Communication to the GPs for residents' change in health status was sighted in the residents' files.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds, (19 skin tears, two skin lesions, six chronic wounds, four abrasions, one infection, and one blister). There are seven residents with grade-one pressure injuries and two residents with grade-three pressure areas (one facility acquired and one present on admission). Pressure-area prevention strategies are included in the long-term care plan. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The Ryman wound care nurse specialist (interviewed) visits twice weekly to review all wound care documentation and assesses all complex wounds with the registered nurses. Staff receive regular education on wound management from the Ryman wound care nurse specialist.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>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.</p>
<p>Standard 1.3.7: Planned</p>	<p>FA</p>	<p>The activity team (nine activities coordinators and two diversional therapists) implement a separate activity</p>

<p>Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programme for the rest home, hospital and dementia areas. All activity team members have a current first aid certificate. The Ryman 'Engage' programme is delivered Monday to Sunday. The Engage programme has been reviewed to ensure that the activities offered are meaningful and relevant for all cognitive capacities and are gender appropriate. The review of the 'Engage' programme has resulted in increased attendance and satisfaction with the activities offered across all services in the past 12 months.</p> <p>Activities were observed to be delivered simultaneously in the rest home, hospital and dementia unit. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There are regular outings/drives for all residents (as appropriate) and involvement in community events.</p> <p>A record is kept for individual residents activities. Activity staff complete recreational progress notes in the residents' files. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan.</p> <p>Resident meetings were held bi-monthly and open for families to attend.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses six monthly or when changes to care occurred. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager and three unit coordinators identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There were 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 safely stored throughout the facility. Safety data sheets were available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 13 August 2016. The facility has three levels of care beds, which are connected to serviced apartments. The hospital level beds are located on the ground floor and second level. The rest home/hospital (eg, dual-purpose beds) is located on level three and the dementia unit is located off level one. There are multiple lifts and stairs between the levels and secure entrance and exits to the dementia unit.</p> <p>The facility employs a team of full-time maintenance staff and contractors as well. Maintenance staff addresses maintenance requests and maintain a 12 monthly planned maintenance schedule. Maintenance staff and external contractors perform electrical testing.</p> <p>Annual calibration and functional checks of medical equipment is completed by an external contractor and was last completed in September 2015.</p> <p>External contractors monitor hot water temperatures in resident areas. Temperature recordings reviewed were between 43-45 degrees Celsius. Contractors are continuously available for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids.</p> <p>The service employs grounds and garden staff that maintain the external areas.</p> <p>Residents were observed to access the outdoor gardens and courtyards safely. Seating and shade is provided.</p> <p>The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms are single occupancy and have ensembles. There were 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.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents rooms were 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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each unit had an open plan lounge and dining area. There were other lounges and rooms available for quiet private time or visitors. The communal areas were easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>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</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>had an entry and exit door with defined clean/dirty areas. There are multiple areas for storing cleaning equipment.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>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. The implementation of a laundry labeller system and individualised clothing bags per resident has reduced the amount of missing items of clothing and is increasing resident and relative satisfaction to the point where there were no complaints about missing clothing.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>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 was a first aid trained staff member on every shift. The Village has an approved fire evacuation plan and fire drills six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has two emergency generators onsite, which are serviced by an external contractor. It also has two gas BBQs available in the event of a power failure and torches. 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 has its own security staff who are employed from 5.30 pm to 6 am Monday to Sunday. The service utilises external security cameras and has internal cameras in the corridors in the dementia/special care unit to promote resident safety.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. There is under floor heating and electric wall heaters in the rest home area only. All rooms have external windows with plenty of natural sunlight. The site is smoke free.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The infection prevention and control programme was appropriate for the size and complexity of the service. There was an infection prevention and control responsibility policy that included a chain of responsibility, and an infection prevention and control officer's job description. The infection prevention and control programme</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>was linked into the quality management system via the RAP. The infection prevention and control committee was combined with the health and safety committee, which meets bi-monthly. 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 had developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. An appointed registered nurse is responsible for infection prevention and control at the facility. She has been in the role for three weeks following the resignation of the previous infection prevention and control officer. She has a signed job description for the role. Staff observe visitors to the site for signs of illness, and advise accordingly. On the days of audit, one resident was ill and there were notices on the door to the resident's room.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>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. The committee includes (but is not limited to), the village manager, the assistant manager, the clinical manager, the infection prevention and control officer, the quality coordinator, the health and safety representative, the educator, a HCA representative and maintenance staff. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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</p>	<p>FA</p>	<p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the templates developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>

type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The infection prevention and control officer has completed online e-learning infection prevention and control training since commencing in the role. The orientation/induction package includes 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 occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections, and are kept as part of the resident files. Infections were included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff were informed through the variety of meetings held at the facility. The infection prevention and control programme was 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 GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been two outbreaks of infection since the previous audit, which was in January 2015. Both outbreaks were confirmed Norovirus. The first outbreak occurred in July, involving 29 residents and 4 staff, and was contained within one week. The second outbreak occurred in September, involving 14 residents and 1 staff and was contained within 10 days. Agencies were notified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The organisation is working towards becoming restraint-free.</p> <p>During the audit, there were five residents using enablers and two residents with restraints. One resident file was reviewed where an enabler (bedrails) was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. There have been improvements made in reducing the number of restraints used without experiencing an increase in the number of residents' falls (link to CI 1.1.8.1).</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital-level residents' files were reviewed (one restraint and one enabler). Completed assessments considered those listed in in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents' care plans. Internal audits conducted measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two residents' files where restraint or an enabler was in use.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly as part of the ongoing reassessment for the residents on the restraint register, and six-monthly as part of the care plan review. Families are included as part of this review. A review of two residents' files identified that evaluations are up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator, clinical services manager, GP and service coordinator where the applicable resident(s) are located. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme, and staff education and training and review.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Process improvements have been made in providing access to a medical practice that operates a medical centre on site, in clarifying advanced care planning preferences, in reducing antibiotic resistance, in the practice of restraint</p>	<p>The facility operates an onsite general practice, which operates five days a week with the goal of increasing access to medical care for patients and normalising the experience of residents visiting the doctor when able. The two general practitioners (GPs) from this practice provide an on call service. Enrolment with the practice is strongly encouraged for all residents, primarily due to the size of the facility. As a result of staff encouragement, the practice at the time of audit serviced all except for one resident and provided onsite services for all residents living in a large number of apartments and villas on the site who wish to enrol with the practice. Residents can be seen by a GP in the medical centre or seen in their rooms. Attendance at the GP practice promotes normal patterns of daily living. Moving to a preferred general practice is a change from previous practice whereby a number of general practices provided services to residents, which generated communication challenges between all parties. Communication issues have been significantly reduced for staff and the GPs. There is a strong relationship between staff and the GPs. The general practice has a genuine commitment to quality (confirmed on interview with both GPs). The GPs have been able to work constructively with the current management and the corporate team to make process improvements for residents.</p> <p>The GPs have worked with Ryman with a goal of developing and further refining and clarifying advanced care planning preferences, as the existing documentation was not considered specific</p>

		<p>minimisation and in falls management.</p>	<p>enough to guide care, especially when patients were in clinical crisis (eg, on admission to emergency departments). The revised advanced care plan has been adopted and implemented nationally throughout Ryman facilities, from August 2015. Edmund Hillary is trialling a revised resuscitation order form that accompanies the advanced care plan. This form has yet to be implemented nationally. Staff and the GPs believe that the revised advanced care plan is providing clear guidance to Ryman and DHB staff. A resident interviewed spoke positively about the advanced care planning process saying that working through the questions had caused them to change their mind and to clarify their preferences.</p> <p>A further process improvement has been implemented with a goal of reducing the rising number of cases of antibiotic resistance in residents. The GPs were approached by the DHB to carefully consider the use of antibiotics. A decision was made in July 2015 to make a process improvement. The GPs worked with the clinical staff and both have changed clinical practice so that only residents who are clinically unwell or who have urosepsis are commenced on antibiotics while a cultured result is sought from the laboratory. The outcome has been less prescribing of antibiotics for residents suspected of having urinary tract infections and an increase in evidenced-based practice as antibiotic treatment is now influenced by laboratory results.</p> <p>Another process improvement has been a reduction in the use of restraints. In July 2015, staff made a decision to actively implement restraint minimisation. One year ago seven residents were using restraints and currently only two residents are using restraints which are being used during the daytime. A range of alternatives were implemented in order to achieve this outcome including the use of low-low beds, sensor mats, intentional hourly rounds by staff, and active involvement in the activities programme so that residents are more visible to staff throughout the day. The reduction in the use of restraint since July 2015 has not contributed to a corresponding trend upward in the number of resident falls over the same period.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where</p>	<p>CI</p>	<p>Robust systems are in place for the collection, analyses, and evaluations of quality data. Results are communicated to staff via a variety of</p>	<p>A range of data is collected across the service using V-care, an electronic data system. Data is collated and analysed with comprehensive evaluation reports completed six monthly. Data analysis is enhanced by using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (eg, manager meetings, full facility meetings, RN meetings). Templates for all meeting document action required, timeframe, and the status of the actions. Specific attention is given to actions that are taking longer than anticipated to be closed off.</p> <p>A range of examples were provided during the audit to reflect quality initiatives, which were identified via trends in data. Responding to call bells was above the threshold in December 2014.</p>

<p>appropriate, consumers.</p>		<p>forums.</p>	<p>Further analysis of data determined that extended call bell response times happened during meal break times and during times when healthcare assistants were very busy (eg, morning cares). A comprehensive action plan was initiated which included discussions in various staff meetings, in-service training, allocation of specific staff to be responsible for responding to call bells during meal times and during handover, and senior staff spending more time on the units during busy periods to motivate staff to answer calls bells. A location analysis was completed for each floor, mapping rooms and trending of call bell responses to rooms. Further actions were undertaken after it was identified that ten residents in particular were experiencing a slow response when their call bell was activated. Actions included transferring these residents closer to the nursing station for closer supervision, and intentional rounding was implemented for these residents. Responses to call bells have dropped significantly over the past seven months (from an average of 50 calls responded to above the target to 15 calls responded to above the target for July 2015).</p> <p>Comprehensive data analysis and trending has also been undertaken relating to the number of residents falls. Falls prevention strategies included intensive staff training programmes to increase their awareness, implementation of intentional rounding, night-lights, early (proactive) GP involvement, and the appointment of senior healthcare assistants. Data reflects a gradual downward trend in the number of falls over a period of one year at the hospital level of care.</p> <p>Other examples of robust data analysis and trending can be attributed to quality initiatives relating to the reduction of pressure injuries and urinary tract infections.</p>
<p>Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>CI</p>	<p>A comprehensive corrective action planning process is in place that is linked to the Ryman quality improvement plan (QIP) process.</p>	<p>The comprehensive corrective action planning process includes: documented evidence of action plans that reflect a thorough review process, including the analysis and reporting of findings and dates of post-implementation evaluation and review; documented evidence of actions taken based on findings and improvement to service provision; and documented evidence of how resident safety has been measured as a result of the review process.</p> <p>Each quality initiative plan (QIP) includes the issue and date, an investigation how the issue occurred, action plans of how improvements will be made and the person(s) responsible with a documented timeframe and review date. The action plan is then evaluated. The issue is either resolved or a new action plan is developed and supporting evidence is detailed. The facility has embedded the QIP process. A focus has been placed on systems for monitoring and determining outcomes, with examples provided (link to CI's 1.2.3.6 and 1.1.8.1). Numerous examples of implemented corrective actions were evidenced throughout this two day audit. An internal spot surveillance audit was conducted in March 2015, identifying shortfalls relating to incomplete residents' long-term care plans. Corrective actions taken were documented and the shortfall was</p>

			<p>rectified. Corrective actions were implemented reducing the number of restraints (link to CI 1.1.8). Corrective actions were implemented reducing urinary tract infections (link to CI 1.1.8). Corrective actions were implemented to increase attendance at activities programmes; and corrective actions were implemented to improve the new employee orientation programme (link to CI 1.2.7.4).</p>
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	<p>A comprehensive orientation programme has been implemented for new staff.</p>	<p>An area identified for improvement relates to ensuring new staff feel welcomed to the team, and confident and competent at the end of their orientation period. Issues had also arisen with staff not completing their orientation. Actions taken included the development of a revised orientation pack for all new staff, designation of orientation 'buddies' within all departments to ensure there is continual support and guidance for all new staff, provision of education and training for the buddies on the expectations of their roles, and the development of an orientation plan for the orientation period. Evaluation of this quality initiative has been undertaken via monitoring the percentage of staff completing their inductions and analysis of feedback received from new staff post orientation. The percentage of staff completing inductions has increased from 77% (1 February 2015) to 94% (1 June 2015). Feedback from staff via staff surveys on the usefulness of their orientation is positive. They report that they feel confident and competent to undertake their role. Furthermore, comments around the length of orientation time is taken into consideration for each employee based on their level of skill and confidence in their role and is adjusted as required from three to five days. This quality initiative remains in process.</p>

End of the report.