

Rita Angus Retirement Village Limited - Rita Angus 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:	Rita Angus Retirement Village Limited
Premises audited:	Rita Angus Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 January 2016 End date: 13 January 2016
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:	76



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

Rita Angus is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home and hospital level of care for up to 89 residents. On the days of the audit there were 76 residents including ten residents receiving rest home level of care in serviced apartments. A village manager, who is supported by an assistant village manager and a clinical services manager, manages the service. The residents and relatives interviewed spoke positively about the care and support provided.

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, relatives, management, staff and a general practitioner.

Areas of continuous improvements have been awarded around good practice, quality programme (reduction of falls and behaviours that challenge), orientation of staff, laundry projects and infection control surveillance (reduction of urinary tract infections).

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.
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Ryman Rita Angus village provides care in a way that focused on the individual resident's quality of life. Cultural assessments are undertaken on admission and during the review process. Policies are 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) is readily available to residents and families. Care plans accommodated the choices of residents and/or their family. Complaint processes were being implemented and complaints and concerns were managed appropriately. Residents and family interviewed verified ongoing 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.
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Rita Angus continues to implement 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 has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. There are human resource policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provided new staff with relevant information for safe work practice. There is an in-service training

programme covering relevant aspects of care and support including external training. 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.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses completed assessments, care plans and evaluations (reviewed) within the required timeframe. 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 general practitioner completes an admission and visits and reviews the residents at least three monthly.

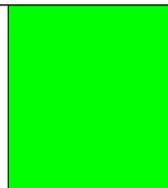
The activity team provide separate programmes for rest home and hospital residents, which includes some integrated activities. The Engage programme meets the abilities and recreational needs of the groups of residents. The programme is varied and involved relatives and the community.

There are policies and processes that describe medication management that align with accepted guidelines. Medicine management complies with legislative requirements. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three monthly.

The menu is designed by a dietitian at an organisational level. Dislikes were known and accommodated. Individual and special dietary needs are accommodated.

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 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. 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. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed 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.

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 with the use of enablers and eight hospital level residents with a restraint. The restraint coordinator maintains a register.

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.

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

The infection prevention and control programme includes policies and procedures to guide staff. The clinical manager and registered nurse share the infection control role. The infection prevention and control committee 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.

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	5	96	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 has policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights. Families and residents are provided with information on admission, which includes the Code of Rights. Staff receive training about resident rights at orientation and as part of the in-service calendar. Interviews with four caregivers (two rest home and two hospital) demonstrated an understanding of the Code of Rights principles.</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 and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families as part of the admission process. Written consents for specific procedures such as student involvement in resident care and indwelling catheter were sighted. Advanced directives are signed appropriately and evidence discussion with the general practitioner. Caregivers 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>Nine files sampled (five hospital residents [including one person under 65 years of age] and four rest home level of care residents) have signed admission agreements, consents and advance directives in place.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented in the resident file.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. The village manager maintains a record of all complaints received by using a complaints' register. The village manager has overall responsibility for ensuring all complaints (verbal or written), are fully documented and investigated. Concerns and complaints are discussed at relevant meetings. Eight complaints were received in 2015 with evidence of appropriate and timely follow-up actions taken. Documentation including follow up letters and resolution, demonstrates that complaints were well managed. Discussion with residents and relatives confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The information pack provided to residents on entry includes the Code of Rights information on how to make a complaint. On entry to the service, the village manager or the clinical manager will discuss the information pack with the resident and their family/whānau. Advocacy brochures are displayed on the noticeboard on each floor. Advocacy is brought to the attention of residents and families on admission and via resident meetings, relatives meetings and the information pack.</p> <p>Interviews with eight residents (four rest home and four hospital) and two relatives (hospital) identified they were aware of their rights and could approach the managers at any time if they have concerns.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>During the audit, staff demonstrated gaining permission prior to entering resident private areas. All care staff interviewed demonstrated an understanding of privacy. Residents and family members</p>

<p>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>interviewed confirm that staff promote resident independence wherever possible and that resident choice is encouraged. Resident values and beliefs information is gathered on admission with family involvement and is integrated with the residents' care plans. Care plans reviewed identified specific individual likes and dislikes. This includes cultural, religious, social and ethnic needs. Interviews with caregivers identified how they get to know resident values, beliefs and cultural differences. There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect staff training occurred in March 2015.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Residents who identify as Māori have their cultural values identified on admission as evidenced on the day of audit. Cultural needs were addressed in the care plan. Family/whānau involvement is encouraged in assessment and care planning. Staff receive cultural awareness training. Links are established with the local iwi and other community representative groups as requested by the resident/family.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Individual cultural needs/requirements, spiritual values and beliefs are identified on admission. Values and beliefs information is integrated into the residents' care plans. Residents and family members interviewed confirm that the values and beliefs of residents are considered. Staff recognise and respond to values, beliefs and cultural differences. A chapel at the service holds weekly church services.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Staff were aware of the actions they should take if they believe a staff member is not maintaining a professional approach to practice.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	CI	<p>Ryman Healthcare has a Ryman Accreditation Programme (RAP) that includes an annual planning and a suite of policies/procedures to provide rest home and hospital care. Policies are reviewed at an organisational level. These documents have been developed in line with current accepted best</p>

<p>appropriate standard.</p>		<p>and/or evidenced based practice and are reviewed regularly. Services are provided at Ryman Rita Angus that adhere to the health & disability services standards. A quality improvement programme that is being implemented includes performance monitoring. The service has successfully reduced the incidence of falls and challenging behaviours.</p> <p>There are human resources policies/procedures to guide practice and an annual in-service education programme that is incorporated into the RAP. There is evidence at Rita Angus that the in-service programme is being implemented. There is a journal club for registered nurses (RN) and enrolled nurses (EN) held bi-monthly in conjunction with the RN/EN meetings. There are implemented competencies for caregivers and qualified nurses. Core competency assessments and induction programmes are being implemented at Rita Angus. RNs have access to external training. Residents and relatives interviewed were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Full information is provided to residents and family/representatives on entry. Families are involved in the initial care planning and ongoing care. Regular contact is maintained with family, including if an incident or care/medical issues arise. Family members interviewed confirmed they are notified following a change of health status of their family member. Accident/incidents forms on the VCare system identified the family had been notified following the accident/incident. There is an interpreter policy and contact details of interpreters are available.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Rita Angus is a Ryman Healthcare retirement village. The service provides rest home and hospital level of care for up to 89 residents (including rest home level care across 20 serviced apartments). There were 76 residents in the facility on the day of audit including 28 rest home residents (10 of who were in serviced apartments), 2 YPD and 46 hospital level residents. There are 40 dedicated dual-purpose beds.</p> <p>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. Village objectives for 2015 have been evaluated. The 2015 village objectives include; (i) Worth a mention (an initiative where staff nominate and promote their peers for monthly recognition), (ii) an initiative to improve knowledge and education of health and safety in the village, (iii) fall...down (a resident focused objective around falls prevention), and (iv) food experience (a resident satisfaction focused objective around improving the food experience).</p> <p>The village manager has been in the role for two and a half years and has previous experience within the media sector. An assistant manager and clinical manager support the village manager. The</p>

		<p>clinical manager (RN) was away on leave the day of the audit. Management are supported by a regional manager (fortnightly visits) and clinical quality auditor (at head office).</p> <p>The village manager has maintained at least eight hours to date of professional development activities related to managing a village that includes the Ryman leadership programme and village manager study days.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Ryman policy outlines manager availability including on-call requirements. During a temporary absence, the assistant manager and clinical manager will cover the manager's role. The assistant manager covers administrative functions and the clinical manager oversees 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.</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>	FA	<p>Rita Angus service continues to implement the Ryman Accreditation Programme (RAP), which links key components of the quality management system to village operations. There are full facility RAP meetings monthly.</p> <p>Outcomes from the RAP Committee are then reported across the various meetings including the 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 bi-monthly. Clinical meeting minutes were sighted. Interviews with staff confirmed an understanding of the quality programme.</p> <p>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. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room.</p> <p>Relative survey was last completed September 2015. Results have been collated with annual comparisons for each service. Benchmarking occurs. Results were fed back to participants through resident and relative meetings.</p> <p>The RAP prescribes the annual internal audit schedule that has been implemented at Rita Angus.</p>

		<p>Audit summaries and QIPs are completed where a noncompliance is identified (<90%). Issues and outcomes are reported to the appropriate committee (eg, RAP, health and safety). QIPs reviewed are seen to have been closed out and resolved.</p> <p>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 (eg, falls). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included involving the physiotherapist to complete mobility assessments for residents identified as high falls.</p> <p>The physiotherapist is included in all multidisciplinary team reviews. The physiotherapist assesses all residents who have falls. Fall prevention strategies have reduced the falls rate (link CI 1.1.8.1.)</p> <p>There is a health and safety, and risk management programme being implemented at Rita Angus. The combined health and safety and infection control committee meet bi-monthly and discussion of incidents/accidents and infections is discussed and documented. There is a current hazard register. The service holds the tertiary level of accident compensation corporation (ACC) partnership.</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>Rita Angus collects monthly incident and accident data and completes electronic recording of events on the VCare system. Monthly analysis of incidents by type is undertaken by the service and is reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and used for comparative purposes. QIPs have been created when the number of incidents exceeded the benchmark. Fifteen accident incident forms reviewed (five rest home and nine hospital) identified timely RN assessment and post falls assessments where required. 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 as evidenced with the outbreak in November 2015.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions, including for RAP officers. Appropriate recruitment documentation was seen in the 11 staff files reviewed. Performance appraisals were current in all files reviewed. Interviews with caregivers informed management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation.</p> <p>There is an annual training plan that aligns with the RAP that is being implemented. The clinical manager oversees the education programme. Staff 'catch up' folders contain education content for staff to read and sign if they were unable to attend training. There is an aged care education officer to</p>

		<p>support staff working towards the national standards. Ryman ensures RNs are supported to maintain their professional competency including attending the bi-monthly journal club meetings and InterRAI training through the Ryman programme. There are five RNs and the clinical manager trained in InterRAI. A register of current practicing certificates is maintained. Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and actively support staff to achieve aged care qualifications, including dementia care modules. Progress is reported monthly to head office as part of the RAP programme.</p> <p>'Worth a Mention' was a 2015 key objective for Rita Angus, an initiative where staff nominate and promote their peers for monthly recognition. All nominated staff go into a pool for management to consider at the end of the calendar year. One staff member receives special recognition at the Christmas function. Rita Angus was the host village for the Ryman kindness project in August 2015, the project was implemented to find the kindest people in the Ryman villages.</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>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. A fulltime clinical manager oversees the care centre. Each unit (rest home and hospital) 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 sufficient staff to meet resident needs.</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 were 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 for services has</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 that describes the services available. The clinical manager</p>

<p>been identified.</p>		<p>screens all potential residents to ensure the service can meet the assessed needs of the residents.</p> <p>The admission agreement reviewed aligns with the service's contracts. Eight admission agreements viewed were signed.</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. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</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. Medicine management complies with ministry of health medicines care guides. An RN completes medication reconciliation on delivery of medication and any errors/discrepancies are fed back to the pharmacy. Registered nurses and senior care staff who administer medications have been assessed for competency on an annual basis. Registered nurses and care staff interviewed were able to describe their role about medicine administration. Education around safe medication administration has been provided annually.</p> <p>Standing orders are not used. The GP and RN have assessed two self-medicating residents (one rest home and one hospital resident) as competent to self-administer.</p> <p>Eighteen medication charts (eight rest home and ten hospital level of care) were reviewed. 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 indication for use. Administration signing sheets correspond with the medication charts.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs qualified chefs who are supported by two other kitchen staff on duty each day. All staff have been trained in food safety and hygiene. The dietitian had reviewed a four weekly seasonal menu at an organisational level. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Special diets such as vegetarian and pureed/soft and gluten free meals are provided. Food is delivered in hot boxes and served from bain maries in the kitchenettes. Fridge and freezer temperatures are checked daily. Chilled goods temperatures are checked on delivery. Twice daily food temperatures are monitored daily and recorded. All foods were date labelled. A cleaning</p>

		schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits.
<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	The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry has been referred back to the needs assessment service or referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The facility has embedded the InterRAI assessments within its clinical practice. InterRAI initial assessments are completed within three weeks of admission and six monthly as the care plan review falls due. All residents have an InterRAI assessment in place. Risk assessments have been completed on admission and reviewed six monthly as part of the InterRAI process. Additional assessments such as management of behaviour, and wound care were completed according to need. In the resident files reviewed the outcomes of all assessments, needs and supports required were reflected in the care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	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 and interventions were documented in detail. Residents and family members interviewed confirm they are involved in the development and review of care plans. Care plans were amended to reflect changes in health status and were reviewed on a regular basis.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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. Contact with relatives was identified in the progress notes by a relative stamp.</p> <p>Wound assessments, treatment and evaluations were in place for minor wounds (skin tears) and two venous ulcers. Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe the referral process to wound nurse specialists if required. The facility has a wound nurse</p>

		<p>champion who reviews all wounds.</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 monitoring, pain monitoring, blood sugar levels and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is an activity team of four (two activity officers have commenced diversional therapy training) to implement a separate activity programme for the rest home and hospital residents. Rest home residents in serviced apartments may choose to attend the rest home programme in the care centre or in the serviced apartments. All activity team members have a current first aid certificate. The Ryman 'Engage' programme is delivered seven days a week in the care centre. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the cognitive and physical abilities of the resident group including residents under 65 years of age.</p> <p>Activities were observed being delivered simultaneously in the rest home and hospital lounges. One-on-one contact is 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, weekly entertainment and involvement in community events such as the community centre, library service and clubs/groups. Pre-school children, school age children, and Duke of Edinburgh students are involved in the programme. On-site church services are held in the facility chapel.</p> <p>A record is kept of individual residents activities. Activity staff complete an activity assessment. Recreational progress notes are maintained in the residents' files. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review.</p> <p>Resident meetings were held bi-monthly in the care centre.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses' six monthly or when changes to care occurred. Written evaluations describe the resident's progress against the residents identified goals. Short-term care plans were in use for infections and evaluated regularly. The multi-disciplinary review involves the primary RN, GP, physiotherapist, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the</p>

		multi-disciplinary care plan reviews and GP visits.
<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>	FA	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 level of care. Discussion with the RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	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 stored safely throughout the facility. Safety data sheets and a spills kit were available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 12 September 2016.</p> <p>The facility employs a fulltime maintenance person. Daily maintenance requests are addressed and a 12 monthly planned maintenance schedule is in place and signed off monthly. Electrical testing is completed biannually. An external contractor completes annual calibration and functional checks of medical equipment.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. Contractors are available 24 hours for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids.</p> <p>Residents were observed to safely access the outdoor gardens and courtyards safely. Wheelchair access, seating and shade is provided. There is a designated smoking area in the courtyard.</p> <p>The RNs and care staff 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. Communal and public 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>The care centre has a separate dining room for the rest home and hospital residents. There is a large lounge with seating placed to allow for individual or group activities. There are smaller lounge/library areas and seating alcoves throughout the facility. The communal areas are easily accessible. The communal areas were easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	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.</p> <p>There are dedicated cleaning and laundry persons on duty each day. The laundry had an entry and exit door with defined clean/dirty areas. 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 confirmed their clothing was treated with care and returned to them in a timely manner. A quality project has been implemented at Rita Angus around missing laundry.</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 policies and procedures to guide staff in managing emergencies and disasters. Emergency management and first aid is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Fire drills occur six monthly. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is available and the service has an arrangement to hire a generator. There are civil defence supplies in the facility and adequate water storage. Call bells are evident in residents' rooms, lounge areas, and toilets/bathrooms. The facility is secure at night.</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. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control officer's role is shared between the clinical manager and a RN. Both have job descriptions that outline their responsibilities. The infection prevention and control committee meets bimonthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is reviewed annually from head office and directed via the RAP annual calendar.</p> <p>Visitors are requested not to visit if they have been unwell. There are hand sanitizers placed throughout the facility.</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 is made up of a cross-section of staff from areas of the service. The infection control officers have attended infection control education through an infection control consultant and the district health board. The ministry of health on-line training course has also been completed.</p> <p>The facility also has access to an infection prevention and control consultant, infection control nurse specialist from the DHB, public health, GPs, local laboratory 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 type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies developed by an infection control consultant. Policies reflect the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<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 officers are responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions. Training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily cares.</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>	CI	<p>The surveillance programme is organised and promoted via the Ryman accreditation programme calendar. Effective monitoring is the responsibility of the infection prevention and control officers. All meetings held at Rita Angus include discussion on infection prevention control. The programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation in New Zealand and Australia. Rita Angus has implemented preventative measures to reduce the incidence of urinary tract infections.</p> <p>There has been one outbreak November 2015. Documentation evidenced the outbreak had been managed appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use</p>	FA	<p>Restraint practices are only used 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.</p>

<p>of restraint is actively minimised.</p>		<p>There were two rest home residents using enablers (bedrail) and eight hospital residents with restraints (four with bedrails, two with harness and two with bedrails and harness) during the audit. The resident files were reviewed where an enabler (bedrails) was in use. Voluntary consent and an assessment process had been completed. The enabler is linked to the resident's care plan and is reviewed six monthly.</p> <p>Staff training is in place around restraint minimisation and enablers and management of challenging behaviours. Staff complete annual restraint competencies.</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. The restraint officer is the clinical manager with a job description that defines the role and responsibility of the restraint officer. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The approval group meets six monthly.</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, approval group, 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. Four hospital level residents' files with restraint use (two bedrails and two harness and bedrails) were reviewed. 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 officer 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 officer/approval group. The use of restraint and risks identified with the use of restraint was linked to</p>

		<p>the four resident care plans reviewed. Internal audits conducted measure staff compliance in following restraint procedures.</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 six monthly as part of the ongoing reassessment for the residents on the restraint register, as part of the care plan review. Families are included in the review of restraint use. Files reviewed for residents with restraint use evidenced evaluation were 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. The restraint officers and members of the approval group attend the meetings. 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. 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.</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>Rita Angus is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. Repeat audit is required if results fall below the Ryman threshold (90%). Issues and outcomes are reported to the appropriate committee, for example RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – (eg, falls rates). QIPs reviewed were seen to have been closed out once resolved. The QIP process was well embedded into</p>	<p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing whether improvements have had positive impacts on resident safety or resident satisfaction.</p> <p>Example of a quality improvement activity included:</p> <p>The service identified an improvement around the management of behaviours that challenge. For 2014 (January to December) there were 58 reported episodes (rest home and hospital) of challenging behaviour/aggression. The incidence was higher in the hospital unit. The QIP included a meeting with clinical staff, analysis of individual residents known to have challenging behaviours, review of the Engage programme, GP review of resident medications, implementation of new education sessions focusing on challenging behaviours and de-escalation techniques, including activities. The service has been successful in better managing challenging behaviours</p>

		day-to-day operations at Rita Angus and includes clinically focused improvements. Two key quality improvement projects identified in 2014 have been around reducing falls (1.2.3.6) and reducing the incidence of challenging behaviours.	reducing the number of reported incidents as 15 for the same period in 2015. Contributing factors have been a) a change in the activity programme to include more activities and more one-on-one time, b) timely medication reviews, and c) increased staff attendance at the new education sessions.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Rita Angus is implementing the RAP quality and risk programme with monitoring determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. Repeat audit is required if results exceed the Ryman threshold (92%). Issues and outcomes are reported to the appropriate committee (eg, RAP). There is evidence of trending of data collected and QIPs being developed when volumes exceed targets, for example falls rates. QIPs reviewed are seen to have been closed out once resolved. The QIP process is seen to have been well embedded into day-to-day operations at Rita Angus and include clinically focused improvements.	Quality improvements identified through the analysis and trending of data included reducing the number of falls in bedrooms. Data was collected monthly over a period of one year with six monthly analysis reports. Staff were kept informed through handovers and regular meetings. Data results for falls identify the service have successfully reduced the number of accidents/incidents for falls. Staff interviewed were knowledgeable in the prevention and appropriate interventions to prevent falls and challenging behaviours and embedded these practices in their daily resident cares and working environment. Example: An analysis of falls accident/incident data identified that falls were happening in resident bedrooms. Individual needs and supports were reviewed to identify why the falls were happening. "What I know about my resident" was initiated at handovers with primary nurses informing all staff of the individual transferring and mobility needs, which led for quick interventions for residents at high risk of falls. The physiotherapist in consultation with the RNs and care staff implemented manual handling charts using the "traffic light" system. These are placed in all resident bedrooms as of July 2014. Staff and visitor awareness has led to less falls in bedrooms. A 'footwear for falls prevention' initiative has been implemented with good staff involvement. Staff refer residents to the physiotherapist who completes a footwear assessment to prevent falls, liaising with the family, podiatrist or orthopaedics as required. Staff attended physiotherapy in-service held in April 2015 on moving and handling and the use of transfer belts and falls prevention training was provided in September 2015. The results over 2015 have been positive with a reduction in the rate of falls. Falls protocols are in place to respond to falls with and without injury. All staff have been involved in actively reducing the rate of falls with caregivers conducting spot checks on sensor mats and completing intentional rounding to pre-empt residents who may attempt to mobilise unaided. A weekly falls report has been discussed

			with staff at handover. The call-bell response time has reduced. From January to March 2015, there were 44 falls in bedrooms (rest home and hospital) with the number of falls in bedrooms reduced to 18 falls September to December 2015.
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	<p>Ryman provides a comprehensive induction programme at Foundations Level 2. The progress of staff completing induction programmes is monitored and reported monthly to head office, as part of the RAP programme.</p>	<p>Rita Angus developed a documented orientation plan to create a welcoming and structured process for new staff to ensure they feel welcomed, supported, confident and competent in their role(s), therefore resulting in improved care for their residents. Rita Angus initiated and commenced the new induction process 1 November 2014. An action plan was developed for the orientation process. Orientation leaders/buddies were set up within all departments to ensure there is continual support and guidance for all new staff. Education was provided for the orientation leaders/buddies on the expectations of the role.</p> <p>Comprehensive buddy checklist forms were developed and introduced along with induction day timetables. All new staff taken through the induction process will not begin their job until the orientation plan has been completed and signed off. There is discussion with staff at the 8-week assessment on settling in and providing feedback on how they found the orientation process and if they feel confident and competent in their role.</p> <p>The village manager and education coordinator meet monthly to review the induction statistics. Induction status is reviewed during monthly RAP meetings and discussed at the monthly staff full facility meeting. Induction statistics were reviewed 31 December 2014. As at 1 December 2014, the percentage of all employee inductions at Rita Angus were completed as 20%, the percentage of overall inductions completed was 24%. In the year 2015, the percentage of all employee inductions at Rita Angus completed within the specified timeframe was 100%, the percentage of overall inductions completed was 98.5%.</p> <p>Outcomes of the new orientation process; Staff feel more confident and competent within their roles, staff feel supported by the entire team, improved team culture, induction completion rate improved. Service provided to the residents is improved, resident satisfaction with care improved and there have been improved call bell responses.</p> <p>On reviewing the Rita Angus induction process and statistics, Ryman rolled</p>

			out nationally, the Ryman Induction Day Plan on 1 October 2015.
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	<p>A quality project has been implemented at Rita Angus around missing laundry. Cleaning and laundry is monitored through the RAP internal audit programme and through satisfaction surveys.</p>	<p>The service implemented the following quality project around missing laundry. Each resident was provided with individually labelled laundry bags for their personal clothing. The organisation purchased a labelling machine and recruited for a new laundry shift whose responsibility was to label all resident personal items on admission and as required. All staff received training on the new labelling machine and laundry processes. Residents and relatives were informed of the labelling procedure. Ongoing discussions at the resident meetings and laundry audits evidenced an improvement in laundry procedures.</p> <p>Survey results for March 2015, resident meeting minutes, and resident/relative interviews on the day of audit evidenced there has been a marked reduction in the number of personal clothing and they were very satisfied with the laundry service. The implementation of a laundry labeller system and individualised clothing bags per resident has reduced the amount of missing/lost items of personal clothing. Photos taken before the project and at the conclusion of the project, evidence successful implementation of the use of the labelling machine. A visit to the laundry on the day of audit demonstrated evidence of the system being implemented with a small amount of clothing un-named.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated,</p>	CI	<p>There is a policy for the definitions of infections. Monthly data for infection events are collated and forwarded to head office. A monthly analysis of infections against the organisations key performance indicators (KPIs) are completed and fed back to the facility. A quality improvement with corrective actions is required for results above the KPIs. Results and corrective actions are discussed at the bimonthly combined health and safety and infection prevention and</p>	<p>In February 2015, urinary tract infections (UTIs) peaked at four per month in the rest home and the hospital units.</p> <p>The service developed a quality improvement plan to reduce the number of UTIs. This included increasing resident hydration by offering fluids in a variety of ways (flavoured drinks, ice-blocks, smoothies) and ensuring fluids were available and accessible to residents such fluids in lighter/smaller jugs in residents rooms and offering regular fluids throughout the 24 hour period. Hydration and infection prevention of UTIs was discussed at all facility meetings. Trolleys were set up with hand hygiene and personal protective equipment that were readily accessible for staff. There was an increased awareness raised around the prevention of UTIs and hand hygiene with education and training on continence, continence products and resident</p>

<p>and reported to relevant personnel and management in a timely manner.</p>		<p>control (IPC) meetings.</p>	<p>personal hygiene. There was good staff attendance at training. All staff demonstrated 100% compliance with hand hygiene competencies. Monthly and six monthly UTI analysis was discussed at the facility meetings. In the rest home, UTI infections reduced to zero from May to November 2015, and have remained below the KPI. In the hospital, UTIs reduced to one in April 2015 with figures remaining on or below the KPI from May to November 2015.</p> <p>The service has been successful in reducing the number of UTIs across the rest home and hospital. The use of antibiotics has reduced and resident comfort increased for residents prone to UTIs.</p>
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End of the report.