

Diana Isaac Retirement Village Limited - Diana Isaac 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:

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| Legal entity: | Diana Isaac Retirement Village Limited |
| Premises audited: | Diana Isaac 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: 11 May 2016 End date: 12 May 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: | 123 |



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 |
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|  | 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 |
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| Yellow | 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 |
| Red | 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

Diana Isaac is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital (geriatric and medical) and dementia care level care for up to 160 residents (120 care centre and 40 certified serviced apartments). On the days of the audit there were 123 residents including four residents receiving rest home level of care in serviced apartments. The service is managed by a village manager who is supported by two clinical managers. 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.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Ryman quality and risk management programme that is individualised to Diana Isaac. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

The facility has embedded the interRAI assessment protocols within its current documentation. Care plans were individualised and comprehensively completed for all resident files reviewed. 'At risk' residents were identified and monitoring strategies were implemented and regularly evaluated.

An improvement is required around meeting interRAI assessment timeframes.

The service is commended for achieving continuous improvement ratings around good practice, reduction of falls, quality initiatives, engage programme, laundry service and infection surveillance.

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.

Diana Isaac provides care in a way that focuses on the individual residents' quality of life. There is a Māori Health Plan and implemented policy supporting practice. Cultural assessments have been 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 are being implemented and complaints and concerns were managed appropriately. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | All standards applicable to this service fully attained with some standards exceeded. |
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Diana Isaac has implemented the 'Team Ryman' programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey has been completed and there were regular resident/relative meetings. Quality and risk performance has been reported across the various facility meetings and to the organisation's management team. Diana Isaac provides clinical indicator data for the three services being provided (hospital, rest home and dementia care). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training was supported. The organisational staffing policy aligns with contractual requirements and included skill mixes.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of low risk. |
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There is a comprehensive information package for residents/relatives on admission to the service. InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses within the required timeframes. 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 visits and reviews the residents at least three monthly.

The activity team provide an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The engage programme meets the abilities and recreational needs of the groups of residents. A village friend's volunteer group are involved in the programme. There were 24-hour activity plans for residents in the dementia 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. The general practitioner reviews medications three monthly.

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

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

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. Staff regularly receive education and training in restraint minimisation and managing behaviours that challenge.

There was one resident using an enabler and two hospital residents with restraints. Consent, assessment, care planning, monitoring and regular evaluation was in place for these residents.

Infection prevention and control

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

nurse who has completed infection control education. Staff receives regular infection control training. Policies and procedures reflect best practice including definitions for surveillance. Monthly infection events are collated and forwarded to head office for analysis and organisational benchmarking. The results of surveillance are used to identify infection control quality initiatives and education requirements. There was one outbreak in 2015 which was well managed by the service.

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) |
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| Standards | 5 | 44 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 6 | 94 | 0 | 1 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| 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 |
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| <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 Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Six families (one rest home, three hospital and two dementia care) and six residents (five rest home and one hospital) interviewed stated they were provided with information on admission which included the Code. Interviews with twelve care assistants (two rest home, five hospital, three dementia care and two serviced apartments) demonstrated an understanding of the Code. Residents and relatives confirm 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 and give informed consent.</p> | FA | <p>Informed consent processes are discussed with residents and families on admission. Written general consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives/care plans are signed for separately. There is evidence of discussion with family when the GP completes a clinically indicated not for resuscitation order. Copies of EPOA are kept on the residents file. Ten caregivers, five registered nurses (RN) and two enrolled nurses (EN) interviewed confirmed verbal consent is obtained when delivering care. Discussion with family member's (one rest home, one hospital and four dementia care relatives) stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Twelve resident files sampled (four dementia, four rest home including one rest home resident in the</p> |

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| | | serviced apartments and four hospital) have signed admission agreements. |
| <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 | 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 reviewed included information on residents' family/whānau and chosen social networks. |
| <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 | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relative and friends are encouraged to be involved with the service and care. |
| <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 | The organisational complaints policy is being implemented at Diana Isaac. The village manager is overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. The facility has an up-to-date complaints register. Concerns and complaints are discussed at relevant meetings. There were six documented complaints made in 2015 and six made in 2016 year to date. Follow-up letters, investigation and outcome was documented. Discussion with residents and relatives confirmed they were provided with information on the complaints process. |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | There is a welcome pack that includes information about the Code. There was also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives informed information had been provided around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The village manager reported having an open door policy and described discussing the information pack with residents/relatives on admission. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p> | FA | Ryman has policies that support resident privacy and confidentiality. A tour of the Diana Isaac facility confirmed personal privacy for residents is maintained. During the audit, staff were observed to be |

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| <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>respectful of residents' privacy by knocking on doors prior to entering resident rooms. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Interviews with care assistants described how choice is incorporated into resident cares.</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>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 the local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.</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>An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</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 job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager and care assistants confirmed an awareness of professional boundaries. Care assistants interviewed 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> | CI | <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 around their policies.</p> |

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| | | <p>A range of clinical indicator data is collected against each the service level and reported through to head office for collating, monitoring and benchmarking between facilities. Feedback is provided to staff via the various meetings as determined by the Ryman programme (previously known as Ryman Accreditation Programme RAP). Quality Improvement Plans (QIP) are developed where results do not meet targets. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch (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. There are a number of examples where this has occurred (link CI 1.2.3.6).</p> <p>A number of quality initiatives have been implemented including (but not limited to): implementation of the Engage Programme to increase attendance at Engage programme and resident enjoyment, implementation of men's club, improve residents' satisfaction with meals and enjoyment with the dining experience, improving satisfaction with laundry service & reducing lost property, introduction of One Chart medication programme and introduction of MyRyman rostering programme.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Family members interviewed confirmed they are notified following a change of health status of their family member. Resident and relative meetings are held regularly. Incident forms reviewed identified family have been kept informed. There is an interpreter policy 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>Diana Isaac Retirement Village is a Ryman Healthcare facility, situated in Christchurch. The service currently provides care for up to 120 residents at hospital, rest home and dementia level care in the care centre and up to 40 rest home level of care residents in the serviced apartments. There were 119 residents in the care centre on the day of audit including 41 rest home, 39 hospital and 39 dementia care residents (across two 20-bed dementia units). The ground floor includes a 40-bed rest home (all dual purpose). There were 40 rest home residents in the ground floor unit. The 1st floor is a 40-bed hospital (also certified as dual purpose). There is one rest home and 39 hospital residents on the 1st floor. There were four rest home residents in the serviced apartments. All residents were under the ARCC agreement.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Quality objectives for the 2015 year have been reviewed and 2016 objectives are in place. There is a health and safety and risk management programme being implemented at Diana Isaac.</p> |

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| | | <p>The village manager at Diana Isaac is non-clinical and has been in the post for six months. The village manager has completed a comprehensive orientation to the role and has attended a two day managers training day. The village manager is supported by two clinical managers. The management team is supported by the Ryman management team including a regional operations manager and clinical practice and audit manager, who were present on the days of audit.</p> <p>The village manager and clinical manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</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 clinical manager will cover the village manager's role with the assistance of the assistant manager. The regional operations 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> | CI | <p>Diana Isaac service continues to implement the Team Ryman Programme, which links key components of the quality management system to village operations. There are full facility Team Ryman meetings monthly. Outcomes from the Team Ryman committee are then reported across the various meetings including the full facility, registered nurse (RN) and care assistants. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Health and safety and infection control meetings are held three monthly. Clinical meeting minutes were sighted. 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 March 2015. Results have been collated with annual comparisons for each service. Areas of concern were identified and quality improvement plans raised, (QIPs) completed and signed off. Results were fed back to participants through resident and relative</p> |

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| | | <p>meetings. Team Ryman prescribes the annual internal audit schedule that has been implemented at Diana Isaac. Audit summaries and QIPs are completed where a non-compliance is identified (<90%). Issues and outcomes are reported to the appropriate committee e.g. health and safety. QIP's reviewed are seen to have been closed out once resolved.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is trending of clinical data and development of QIPs when volumes exceed targets (e.g., 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. 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.</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>Diana Isaac collects monthly incident and accident data and completes electronic recording of events on the V-Care 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.</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>Eight of eighteen RNs (including the clinical manager) have completed their interRAI training.</p> <p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are job descriptions for designated officers. Appropriate recruitment documentation was seen in the 14 staff files reviewed. Performance appraisals are current in all files reviewed. Interviews with care assistants inform that management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained.</p> <p>There is an annual training plan aligned with the Team Ryman programme that is being implemented. 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 coordinator/EN to support staff working towards the national standards. Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings and completing interRAI training through the Ryman programme.</p> |

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| | | Fifteen out of nineteen care assistants who are employed in the dementia care unit have completed their dementia specific units. Four care assistants are in the progress to complete their dementia specific units and have commenced work in the last 12 months. Completion of induction programme and required dementia standards are required to be monitored and reported monthly to head office as part of the Team Ryman programme. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is at least one RN and first aid trained member of staff on every shift. Caregiver's advised that RN's (including coordinators) are supportive and approachable. Staff advised that there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are sufficient staff to meet resident needs, however staff on weekends are busier. There is access to both casual staff and part-time staff to cover unexpected absence. The caregivers cover a mix of long and short shifts. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24-hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard in both areas. Care plans and notes were legible and where necessary signed (and dated) by a RN. Entries reviewed were legible, dated and signed by the relevant care assistant or RN including designation. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. Information gathered on admission is retained in residents' records. Six relatives interviewed (three hospital, one rest home and two dementia care) 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 dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy. The admission agreement reviewed aligns with the service's contracts. |
| Standard 1.3.10: Transition, Exit, | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and |

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| <p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | | <p>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 medication requirements. The service uses an electronic medication system. Medication reconciliation is completed by an RN on delivery of medication and any errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior care staff in the dementia care unit who administer medications, have been assessed for competency on an annual basis. Qualified nurses and care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly.</p> <p>Standing orders are not used. One self-medicating resident in the rest home had been assessed and reviewed three monthly by the GP and RN as competent to self-administer.</p> <p>Twenty-four (eight hospital, eight rest home and eight dementia care) medication charts were reviewed on the electronic medication system.</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 a qualified head chef who is supported by a chef assistant, cooks and kitchen assistants. All staff have been trained in food safety and chemical safety. There is a four weekly seasonal menu that had been designed in consultation with company chefs and the dietitian at organisational level. All meals are prepared and cooked on-site.</p> <p>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 are known. Alternative foods are offered. The menu includes a second evening meal option and a chef's choice fortnightly. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft and diabetic desserts are provided. Food is delivered in scan boxes and served from bain maries in each of the unit kitchenettes. "Food on the run" are delivered to the dementia care units daily and as required. Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits.</p> |

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| <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 service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>The facility has embedded the interRAI assessment protocols within its current documentation (link 1.3.3.3). Risk assessments have been completed on admission and reviewed six monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments as triggered were reflected in the care plan. Additional assessments such as behavioural, wound and restraints 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> <p>For the four dementia resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans. Additional assessments for management of behaviour, wound care and nutrition were appropriately completed according to need.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Rest home/ hospital care:</p> <p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans were resident-centred and support current needs. Interventions were documented in detail to reflect the outcomes of clinical assessments. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. Residents and family stated they were involved in the care planning and review process. Residents interviewed (one hospital and five rest home) and relatives stated that they were involved in care planning and reviews.</p> <p>Dementia care:</p> <p>Four dementia files reviewed. All four care plans reviewed were comprehensive and demonstrated service integration and input from allied health. Care plans sampled were resident-centred and support current needs. Long-term care plans were updated for changes in health status and were evaluated on a regular basis and signed off as resolved. There was evidence of service integration with documented input from a range of specialist care professionals. Behaviour management plans were in place for all four residents.</p> |

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| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Rest home/hospital care</p> <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 or nurse specialist consultant. Resident care plans are updated to reflect changes in care. Short-term care plans are used for infections.</p> <p>Wound assessments, treatment and evaluations were in place for all current minor wounds; three chronic ulcers (one hospital and two rest home) and one stage II sacral pressure injury (hospital level). Adequate dressing supplies were sighted in the treatment rooms. The wound care champion/enrolled nurse had previously been a district nurse with experience in complex wounds. She has attended a pressure injury seminar in 2015 and delivers on-site education and training for all staff in wound care. Wound care advice and support can be sought from the district nursing service or wound product representative as required.</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 RN's 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, two hourly position charts and behaviour charts.</p> <p>Dementia care:</p> <p>The four dementia care plans reviewed included documentation that meets the need of the residents. Where resident needs had changed, care plans had been updated. Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members interviewed stated care and support is good and that they are involved in the care planning. Monitoring charts were well utilised in the dementia unit and examples sighted included (but not limited to): weight and vital signs, blood glucose, pain, food and fluid and behaviour monitoring.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements</p> | <p>CI</p> | <p>There is a team of activity coordinators who implement separate activity programmes for the rest home, hospital and dementia units. The Ryman 'Engage' programme is currently delivered Monday to Friday in the rest home and hospital area. There are two activity coordinators in the dementia care units (one for each unit) seven days a week 9.30pm to 6pm. All activity team members have a current</p> |

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| <p>are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>first aid certificate</p> <p>The Engage programme was implemented on a trial basis in June 2104 and fully implemented from March 2015. There are set Ryman activities with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Activities were observed to be delivered simultaneously in the rest home, hospital and dementia units. Residents in the dementia care unit were observed being taken for supervised walks outside. Rest home residents in the serviced apartment may choose to attend either the serviced apartment or rest home programme. Lounge carers provide one on one activities. Volunteers are involved in activities such as art and crafts, board games and bowls. There has been an increase in attendance at Engage activities particularly in the hospital and dementia care units for which the service has been awarded a continuous improvement.</p> <p>There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events. Residents are encouraged to maintain former links with community groups. Wheelchair access vans are hired for special community outings. There are on-site interdenominational church services.</p> <p>Activity assessments are completed for residents on admission. The activity plan in 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 and review of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident/relative meetings and satisfaction surveys.</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 across the three areas had been evaluated by registered nurses' six monthly or when changes to care occurred. Written evaluations describe the resident's progress against the residents/relatives identified goals. The multidisciplinary team review involves the RN, GP, 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 medical review by the GP. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. InterRAI assessments had been completed at the time of care plan evaluations in the files of rest home and hospital residents.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> | <p>FA</p> | <p>Referral to other health and disability services is evident in the resident files reviewed. 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 clinical manager and four unit coordinators</p> |

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| <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>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 are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets and product use information was readily available. Staff have attended chemical safety.</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 1 August 2016.</p> <p>The facility employs a full-time and part-time maintenance person and gardens and grounds staff. The maintenance person has a current advanced site safety certificate. Daily maintenance requests are addressed and a 12 monthly planned maintenance schedule is in place and has been signed off monthly (sighted). Essential contractors are available 24-hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>The care assistants and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The dementia care unit provided an open plan dining/lounge area. There is free and safe access to and from two outdoor decks with raised gardens, seating and shade.</p> |

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| <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 toilet and shower 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. All beds are electric with some ultra-low beds in place.</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 has a functioning kitchen unit and dining area. Large lounges have seating placed to allow for individual or group activities. There is a smaller lounge/library area and seating alcoves in the rest home and hospital units. The communal areas are easily accessible. The dementia care unit has a spacious open plan dining/lounge area with seating placed appropriately to allow for low stimulus, small group and individual activities. The communal areas in the dementia unit were easily and safely accessible for residents. During the day in the dementia unit, the door between the two lounges of each unit is kept open for residents to wander. The nurse's station is positioned to monitor both lounges.</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> | CI | <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 Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</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 confirmed their clothing was treated with care and returned to them in a timely manner. The service has been awarded a continuous improvement rating</p> |

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| | | for the labelling process that has reduced the number of missing clothing items. |
| <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> | FA | <p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and cardiopulmonary resuscitation (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 dated 22 August 2012.</p> <p>Fire drills occur six monthly. The service has a diesel generator on-site, gas barbeque and cylinders, sufficient water held in ceiling tanks and food in the event of an emergency event. Emergency lighting is in place. An electronic call bell system was evident in all resident's rooms and ensuites, communal toilets and communal lounge and dining areas. The building is secure after-hours. The dementia care unit has secure access.</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> | FA | <p>General living areas and resident rooms are appropriately ventilated and heated with under-floor heating. 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> | FA | <p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control committee is 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 quality programme. The programme is reviewed annually and six month analysis is completed at Diana Isaac. The facility has 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. The ICN has been in the role for a month with support by the clinical manager. She has a signed job description for the role. A norovirus outbreak December 2015 was well managed and included a debrief meeting to review overall management by staff.</p> |
| <p>Standard 3.2: Implementing the</p> | FA | <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 IC officer has completed an IC</p> |

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| <p>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>induction within the organisation and MOH training. 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 type of service provided.</p> | <p>FA</p> | <p>There is comprehensive infection prevention and control policies that are current, reflect standards, 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> | <p>FA</p> | <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 hygiene 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> | <p>CI</p> | <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 are 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 are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention</p> |

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| | | 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. |
| <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 one resident using an enabler and two residents with restraints. The 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> | FA | <p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (CM) 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.</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> | FA | <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 was evident. Two hospital-level residents' files were reviewed (chair brief restraint and bedrail restraint). Completed assessments considered</p> |

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| | | those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use Services use restraint safely | FA | <p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is the clinical manager 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. 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 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> |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | 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 were up to date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator, RN, GP and unit 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/training and review. |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | PA Low | <p>Twelve resident files (four hospital, four rest home, four dementia) were reviewed. In all 12 files, care plans and evaluations reviewed had been completed within the required timeframes. InterRAI assessments were completed within the required timeframes in the rest home and hospital files reviewed. Three of four dementia files reviewed had an interRAI assessment completed. Two of the three had not been completed within the required timeframes.</p> | <p>One of four dementia files reviewed did not have an interRAI assessment completed. The three dementia files that did have an interRAI assessment completed did not have this completed within the required timeframes.</p> | <p>Ensure all residents have an interRAI assessment completed within the required timeframes.</p> <p>90 days</p> |

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 |
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| <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>Ryman has robust quality and risk management processes which is well established at Diana Isaac. The quality programme is directed from Ryman Christchurch (head office). A quality assistant checklist is completed monthly. Six monthly comparative incident/accident reports and infection reports are completed. Policies and procedures cross-reference other policies and appropriate standards. There is an organisational clinical management committee at Ryman Christchurch (head office) that reviews best practice, legislation, standards, research and policy and procedure review. All changes made to policy, procedure and processes are forwarded to Diana Isaac for input and review. There is a journal club (registered nurses/enrolled nurses), articles/research and questions directed by Ryman Christchurch are completed at the journal club. There is evidence of clinical development and review of practice at Diana Isaac. The focus of care is around a multidisciplinary</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 if the improvements have had positive impacts on resident safety or resident satisfaction. Example: the service implemented a project in the special care unit around reducing and better managing incidents of challenging behaviours. An action plan was implemented that included (but not limited to): analysing the incidents, team discussions, liaising with the leisure and lifestyle manager around activities that could be used to engage residents more and further staff education. The evaluation of the project identified reduction in behaviour incidents from 7 per 1000 bed</p> |

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| | | <p>model and includes input from resident, relatives, care giving staff, registered nurses and GP. Care planning is holistic and integrated. There is a strong commitment to staff development by way of education and in-service training. There are also experienced registered nurses (including the clinical manager and clinical coordinator) who provide leadership.</p> <p>Click here to enter text</p> | <p>nights in November 2015 to 1 per 1000 bed night in February 2016. The numbers continue to remain low.</p> |
| <p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | <p>CI</p> | <p>Robust systems are in place for the collection, analysis and evaluations of quality data. Results are communicated to staff via a variety of forums. 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 monthly and comparative reports six monthly. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other similar service types within Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management meetings, full facility meetings, clinical meetings). Templates for all meetings document action required, timeframe and the status of the actions.</p> | <p>Data collated is used to identify any areas that require improvement. The quality programme for 2016 includes objectives for improving outcomes for residents. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is collected around (but not limited to): falls, skin tears, pressure injuries and infections. Falls in the rest home were identified as an area that required improvement from data collected from 2015. A plan was developed as part of their 2016 quality goals which included identifying residents at risk of falling, providing falls prevention training for staff, reviewing call bell response times, reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the activities programme and reviewing of clinical indicator data. Further initiatives implemented included 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 and increased staff awareness of residents who are at risk of falling. The plan has been reviewed monthly and discussed at staff meetings. Education and training for staff has been regularly provided. Evaluation identified that the rest home has remained under the limit reference range for falls (11 per 1000 bed nights) in 2015.</p> |

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| <p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p> | <p>CI</p> | <p>The service's plans and operational structures combine to provide a comprehensive quality development and risk management structure. Formal review of the Diana Isaac facility objectives takes place annually and informally monthly.</p> <p>Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six month period. Reports and implementation of the quality system is monitored closely by Ryman head office. Internal audits are completed and include the identification of any issues and corrective actions where required. Results are discussed at the monthly quality/management meetings and other facility meetings. Annual resident and relative satisfaction surveys are completed.</p> | <p>Diana Isaac has identified quality goals for each year. The service reports on progress to meeting quality goals monthly and annually. One quality goal was around pressure injury prevention. A trend analysis was completed around pressure injury rates. A plan was implemented to meet this quality goal that included (but not limited to): review of pressure relieving equipment for those residents at risk, ongoing in-service education, review of PIs monthly with identified corrective actions and discuss at clinical and management meetings. Ongoing evaluation of the quality goals and strategies are reviewed for effectiveness at monthly meetings. The 2015 outcome identifies that Diana Isaac has remained below upper limit range. Diana Isaac is also ranked number 1 across the Ryman group for lowest rates of stage II pressure injuries and ranked 2nd out of 26 villages for lowest rates of stage I pressure injuries.</p> |
| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | <p>CI</p> | <p>The service identified an area for improvement around the activities provided to increase resident enjoyment in activities and increase resident attendance. The activity programme was reviewed with a focus on residents engaging in activities. Residents and staff were informed about the changes to the programme and the implementation of the Engage programme. Diana Isaac was the "pilot" home for the improved programme.</p> | <p>Staff became involved with the Engage programme. The programme includes more opportunities to engage with residents and getting to know them better. A lounge carer position in the care centre coordinates and provides activities in small groups or individual basis. The triple AAA exercise programme is delivered twice daily in the dementia care units with a later afternoon session that was observed to have good attendance and participation on the days of audit. A men's and couples group have regular outings and activities with good participation.</p> <p>The initiative has been successful in achieving increased attendance in the Engage programme. Evidence of attendance at general activities include hospital level in April 2015 was 963 and in April 2016 was 1410; rest home has been consistently high between 1000 and 1523 over the past year and dementia unit attendance in January</p> |

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| | | | <p>2015 was 1,210 and in January 2016 was 2,242. Resident survey satisfaction results had increased around activities from 2015 to 2016.</p> <p>The service is currently the “pilot” home for the introduction of Ryman live computer tablets that residents can access for checking weather, ancestry websites, emailing, skypeing family, games, music and films.</p> |
| <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 continuous improvement project was commenced in January 2015 to increase resident and relative satisfaction with laundry services. Missing/lost clothing items had been identified as a resident/relative concern in resident surveys and resident meetings.</p> | <p>Each resident was provided with individually labelled laundry bags for their personal clothing. The purple resident clothing bags were seen in resident ensuites. The organisation purchased a labelling machine and recruited for a new laundry shift whose responsibility is to label all resident personal items on admission and as required. All staff received training on the new labelling machine and laundry processes. The laundry person interviewed on the day of audit could describe the procedure for reducing the amount of missing clothing. 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>Resident satisfaction survey results from September 2016 to February 2016 evidenced increased satisfaction with the laundry service.</p> <p>Resident/relative interviews on the day of audit confirmed there has been a marked reduction in the number of personal clothing going missing 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</p> |

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| | | | of the system being implemented with a small tray of un-named clothing. |
| <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, and reported to relevant personnel and management in a timely manner.</p> | CI | <p>Infections are 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 are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. Infections are benchmarked across Ryman and quality action plans are identified where infections are above the benchmark.</p> | <p>The IC team at Diana Isaac identified that UTIs were high across the care centre. A continuous improvement quality action plan was established following a trend analysis of UTI rates. Strategies were documented and implemented including (but not limited to): specific tasks for the fluid assistant, training for staff, handover reminders and liaising with the GP to review interventions and medications of those residents with recurrent UTIs. Ongoing review of this action plan since April 2015 included an analysis and review/effectiveness of strategies through the clinical meetings and full facility meetings monthly. The evaluation identified UTIs have reduced in the rest home (November 2015– March 2016) and hospital (December 2015 – March 2016).</p> |

End of the report.