

# Evelyn Page Retirement Village Limited - Evelyn Page Retirement Village

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## 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:

<b>Legal entity:</b>	Evelyn Page Retirement Village Limited
<b>Premises audited:</b>	Evelyn Page Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 28 November 2016    End date: 29 November 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	120



# Executive summary of the audit

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## 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
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

Ryman Evelyn Page provides rest home, hospital (geriatric and medical) and dementia level care for up to 137 residents. On the day of audit there were 120 residents.

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

The village manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. The service has been actively working on reducing the number of adverse events, reducing turnover of staff and improving communication with service users. Feedback from residents and families was very positive about the care and services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

The service is commended for achieving four areas of continuous improvement around good practice, the activities programme, food and nutrition and the laundry service.

## Consumer rights

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

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

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints.

## 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.

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

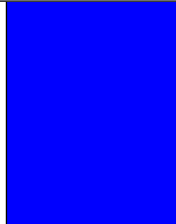
A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

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

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Residents and family interviewed confirmed they were involved in the care planning process and review. Care

plans were updated for changes in health status. The general practitioner completes an admission assessment and 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.

A dietitian, at an organisational level, designs the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available around the clock for residents in the dementia care unit. Residents interviewed responded favourably to the food provided.

## Safe and appropriate environment


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

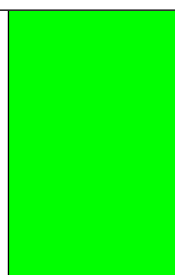
Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

## 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.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained by the restraint coordinator. During the audit nine residents were using restraints and two residents were using enablers.

## Infection prevention and control

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



benchmarking. A six-monthly comparative summary is completed. The service has successfully managed to contain two gastroenteritis outbreaks during the periods September 2015 and June 2016.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	4	46	0	0	0	0	0
<b>Criteria</b>	4	97	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Four managers (one village manager, one assistant manager, one clinical manager, one regional manager) and twenty-three care staff (nine registered nurses (RNs); eight caregivers (two serviced apartments, two dementia (special care unit), two hospital and two rest home covering both AM and PM shifts), one serviced apartment coordinator and five activities staff) described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their enduring power of attorney (EPOA) signs written consents. Advanced directives 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' files. Eight caregivers and nine registered nurses (RN) interviewed confirmed verbal consent is obtained when delivering care. Discussions with family members confirmed that the service actively involves them</p>

give informed consent.		<p>in decisions that affect their relative's lives.</p> <p>Eleven resident files sampled (four dementia, four rest home- including one rest home resident in the serviced apartments and three hospital residents) have signed admission agreements.</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>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/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on the resident's family/whānau and chosen social networks.</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>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. Links were identified with local schools, the volunteer programme, the retired services association and Age Concern. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</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 service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. All complaints received in 2016 (two hospital level, four rest home level, four serviced apartment level) were documented as resolved.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Nine relatives (one rest home, four hospital, four dementia (special care unit) and sixteen residents (nine rest home including one in a serviced apartment, seven hospital) stated they were provided with information on admission which</p>

rights.		included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors were closed while cares were being done.  The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into resident cares. Staff attend education and training on abuse and neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Ryman has a 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 local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. There were no residents who identified as Māori at the time of the audit.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (formerly known as head office) for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman programme (previously known as Ryman Accreditation Programme RAP). Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.</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>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arises. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Twenty incident/accident forms and corresponding residents' files were reviewed and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p>

		Access to interpreter services is available if needed for residents who are unable to speak or understand English. There were two residents in the dementia unit who occasionally reverted to their first language. Family and staff are available to interpret.
<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>	FA	<p>Evelyn Page is a Ryman retirement village located in Orewa. The service is certified to provide rest home, hospital (geriatric and medical) and dementia level care in their care centre for up to 117 residents. In addition, there are 20 serviced apartments certified to provide rest home level care.</p> <p>There are 40 dual purpose beds on the ground level where there were 25 hospital level and 15 rest home level residents. The hospital wing (40 beds) is on the second floor and was also full with 40 residents during the audit. There are two dementia units on the third level with nineteen and eighteen beds respectively. Occupancy was 35 (19 residents and 16 residents). There are five rest home level residents in the serviced apartments. Two of the hospital level residents were on respite (one private and one discharged on day one of the audit).</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Organisational objectives for 2016 were created around the letter 'T' (one team, turn, timely and take ownership) with evidence of monthly reviews and quarterly reporting on progress towards meeting these objectives.</p> <p>The village manager has been in her role for three year and has been employed by Ryman since February 2011. She has over 14 years of experience in managerial roles and has attended over eight hours (year to date) of professional development activities related to managing an aged care facility. She is supported by a regional manager, an assistant manager and a clinical manager/RN.</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>The clinical manager and assistant manager are responsible during the temporary absence of the village manager, with support from the regional manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	FA	<p>Evelyn Page has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and 29 staff (twenty-</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>three care staff, one maintenance, one cleaner, three laundry staff, one kitchen manager) and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.</p> <p>Regular resident and family meetings are conducted. Meetings are held specific to the level of care. Minutes are maintained. Annual resident and relative surveys are completed with a quality improvement plan developed if there is an area identified for improvement.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting.</p> <p>Systems are implemented for the collection, analysis and evaluation of quality data. A range of data (e.g., falls, pressure injuries, challenging behaviours, infections) is collected across the service using an electronic data system. Data is collated and analysed with evaluation reports completed six-monthly. Data analysis describes variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings (e.g., management meetings, full facility meetings, team Ryman meetings). Templates for all meetings document action required, timeframe and the status of the actions.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings. A health and safety officer is appointed who has completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice (expiry 31 March 2017).</p> <p>Falls prevention strategies are in place including but not limited to: a 'traffic light' system to identify those at high risk of falling, intentional rounding, the development of a falls calendar, physiotherapy input and regular exercise programmes that link to the Otago falls prevention programme.</p>
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<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>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of 20 incident/accident forms for 2016 identified that all are fully completed and include follow-up by a registered nurse. The adverse event reporting process is linked to the quality and risk management system.</p> <p>The village manager was able to identify a range of situations that required reporting to statutory authorities (one pressure injury notification and four gastroenteritis outbreaks. Two sudden deaths in 2016 required coroners input to determine case of death. Both were identified as natural causes. A section 31 for both deaths was filed &amp; evidenced during the audit.</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>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (six RNs, three caregivers, one laundry, two activities coordinators, one housekeeper, one kitchen assistant) included an application form, interview and reference checks, signed employment contracts, job description relevant to the role(s) the staff member is in, completion of a general and job-specific orientation programme and annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. Training is repeated to ensure all staff are able to attend. There is an attendance register for each training session and an individual staff member record of training. Twenty-two of thirty-four caregivers who work in the dementia units have completed their required dementia qualification. The remaining twelve staff have worked in the dementia units for less than one year and are working towards completing their qualification.</p> <p>Registered nurses are supported to maintain their professional competency. Seven out of twenty-four registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures or treatments including medication and insulin competencies.</p>



<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. There is a minimum of two RNs and eight caregivers on-site at any time. Activities are provided seven days a week in the hospital and dementia unit.</p> <p>In addition to staff RNs, RN cover includes a full-time unit coordinator for the 40 bed dual purpose rest home/hospital floor, a hospital unit coordinator for the 40 bed hospital unit and a special care coordinator for the dementia units. The unit coordinator for the serviced apartments is a foreign trained nurse. A minimum of one senior caregiver is on duty in the serviced apartments during the night shift with additional staffing on the AM (four caregivers) and PM (three caregivers) shifts. Staffing throughout the facility meets contractual requirements and is adjusted based on the number of residents and their acuity.</p> <p>Staff were visible during the audit and were attending to call bells in a timely manner as confirmed by all residents and families interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack for residents being admitted to the secure dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy.</p> <p>The admission agreement reviewed aligns with the service's contracts. Eleven admission</p>

		agreements viewed were signed. Exclusions from the service are included in the admission agreement.
<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>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. One rest home file was reviewed of a respite resident that had been transferred to hospital acutely. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised blister packs for regular and 'as required' (PRN) medications. Medication reconciliation is completed by an RN on delivery of medication and any errors are fed back to the pharmacy. All medications were securely and appropriately stored on day of audit. There are weekly and six-monthly controlled drug checks.</p> <p>All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RN's have completed syringe driver training.</p> <p>Twenty-two medication charts were reviewed (eight rest home –including two residents receiving rest home care in the serviced apartments, six hospital and eight dementia) The service uses an electronic medication management system. All medication charts reviewed have 'as required' medications prescribed with an individualised indication for use. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly. The medication folders include a list of specimen signatures.</p> <p>Staff were observed to be safely administering medications. Registered nurses and care staff interviewed could describe their role in regard to medicine administration. Standing orders are not used. Seven self-medicating residents (rest home) had been assessed by the GP and RN as competent to self-administer.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges. There is a signed agreement with the pharmacy.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>CI</p>	<p>The service employs a qualified head chef who is supported by cooks and kitchen assistants. All staff have been trained in food safety and chemical safety. A four-weekly seasonal menu had been designed in consultation with company chefs and the dietitian, at organisational level. All meals are prepared and cooked on-site. The service has implemented a food service improvement project, which has resulted in an increase in resident satisfaction with the food service.</p> <p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as a resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as pureed, soft and diabetic desserts are provided. Food is delivered in scan boxes and served from bain-maries in each of the unit kitchenettes. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits. The head chef maintains regular contact with residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred 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>	<p>FA</p>	<p>The facility has embedded the interRAI assessments within its clinical practice. 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 (triggered) were reflected in the care plan. Additional assessments such as behavioural, wound and restraints 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>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans reviewed were resident centred and support needs and interventions were documented in detail to reflect the outcomes of clinical assessments. Care</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>plans reviewed were amended to reflect changes in health status and were reviewed on a regular basis. Family members interviewed confirm care delivery and support by staff is consistent with their expectations</p>
<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>When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Communication to the GPs for residents' change in health status was sighted in the resident's files. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds. There were four residents with facility acquired stage II resolving to stage I pressure injuries. Pressure injury prevention strategies are included in the long-term care plan. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The Ryman wound care nurse specialist visits the care centre and supports the work completed by the on-site registered nurse, wound care nurse and the registered nurses. Staff receive regular education on wound management.</p> <p>Contenance 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, 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>	<p>CI</p>	<p>The Engage programme has been reviewed to ensure that the activities that are offered are meaningful and relevant for all cognitive capacities and are gender appropriate. The review of the Engage programme has resulted in increased attendance and satisfaction with the activities offered across all services in the past 12 months.</p> <p>Six activity coordinators implement a separate activity programme for the rest home, hospital and dementia units. The Ryman 'Engage' programme is currently delivered Monday to Friday in the rest home and hospital areas. There are two activity coordinators (one for each unit) providing activities in the dementia unit over the seven-day week from 9.30am – 6.30pm. All activity team members have a current first aid certificate. One activity coordinator in the dementia care unit has completed dementia unit standards and the other is progressing through the standards.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities</p>

		<p>that are meaningful and relevant for all cognitive and physical abilities of the resident group. Residents in the dementia care unit were observed being taken for supervised walks outside. Spontaneous pet therapy sessions occur.</p> <p>Activities were observed to be delivered simultaneously in the rest home, hospital and dementia unit. Rest home residents in the serviced apartment may choose to attend either the serviced apartment or rest home programme. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. 'Village friends' is a group of village volunteers who are involved in the activities programme. The volunteer group has been beneficial for residents who require one-on-one time and small group activities such as the men's group.</p> <p>There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events.</p> <p>Resident meetings were held bi-monthly and open to families to attend.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident 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 had been evaluated by registered nurses six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review 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 multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager and four unit coordinators identified that the service has access to a wide range of support</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>either through the GP, Ryman specialists and contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets were available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility has three service levels across three floors. The serviced apartments are accessed from the ground floor. There are 40 hospital beds on the ground floor, 40 dual purpose beds on level 1 and 37 dementia beds split into 2 wings of 19 and 18 beds on level 2. There are multiple lifts and stairs access between the levels and secure entrance and exits to the dementia unit.</p> <p>The building has a current building warrant of fitness that expires 6 September 2017.</p> <p>The facility employs two maintenance staff (full-time and on call) and gardens and grounds staff. 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. 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. Currently air conditioning units are being installed in the serviced apartment area.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise safely using mobility aids.</p> <p>Residents were observed safely accessing the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The dementia care unit includes an open plan dining/lounge area. There is free and safe access to an outdoor deck area with raised gardens, seating and shade.</p>

		There is a men's shed in one of the courtyards.
<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	All bedrooms are single occupancy and have ensuites. 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>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	Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Bedrooms are personalised. Bedroom doors in the dementia unit have door photographs to aid resident identification of their room.
<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	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 hospital and other areas. The communal areas are easily accessible. The dementia care units have spacious open plan dining/lounge areas with seating placed appropriately to allow for low stimulus, small group and individual activities. There is a smaller family/whānau lounge for quiet activities or family visits. The communal areas in the dementia unit are easily and safely accessible for residents.
<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 internal audit programme. The laundry had an entry and exit door with defined clean/dirty areas. There are multiple areas for storing cleaning equipment.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day.</p>

		<p>All linen and personal clothing is laundered on-site. A project was implemented to reduce the number of resident items misplaced in the laundry. Resident and family interviewed reported increased satisfaction with the laundry service.</p> <p>Nine-housekeeping staff have completed a level two cleaning and caretaking course. A project to sustain resident satisfaction with the housekeeping service has been implemented with residents expressing satisfaction with this service. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas.</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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting and cooking facilities are in place. There are civil defence kits in the facility and stored water on-site.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advise that they conduct security checks at night, in addition to an external contractor.</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 underfloor 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 was appropriate for the size and complexity of the service. There was an infection prevention and control responsibility policy that includes a chain of responsibility and infection prevention and control officer's job description. The infection prevention and control programme is linked into the quality management system.</p> <p>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 an annual</p>



		<p>calendar. The facility has developed links with the GP's, local laboratory, the infection control and public health departments at the local DHB. There is an appointed registered nurse who is responsible for infection prevention and control at the facility. The infection control nurse has been in the role for three years. A signed job description for the role was on file. Staff observe visitors to the site for signs of illness and advise accordingly. Residents are offered the annual influenza vaccine. Hand sanitisers are strategically 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>	FA	<p>The infection prevention and control committee (combined with the health and safety committee) consists of a cross-section of staff from areas of the service. The infection control and prevention officer has completed training via the Ryman annual infection control teleconference and has attended external education September 2016.</p> <p>The facility also has access to an infection prevention and control consultant, 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>	FA	<p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. 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 officer is responsible for coordinating/providing education and training to staff. The infection prevention and control officer has completed online e-learning infection prevention and control training since commencing in the role. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance programme is organised and promoted via the Ryman calendar. Effective monitoring is the responsibility of the infection prevention and control officer who is a registered nurse. An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the bi-monthly combined health and safety and infection prevention and control (IPC) meetings.</p> <p>Six-monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Ryman Evelyn Page include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation.</p> <p>There have been two outbreaks since the last audit, one in September 2015 and one in June 2016. The outbreaks were well managed according to the MOH guidelines for the management of outbreaks and all reporting requirements were met.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were nine hospital level residents with restraint and two hospital level residents using enablers.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) 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>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident</p>

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>and their family/whānau. 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. The file for two hospital level residents using restraint and one hospital level resident using an enabler were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is 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, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the resident's files reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify one and two hourly checks were evidenced on the monitoring forms for the two residents' files used where restraint was in use.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in two residents' files where restraint was in use. The restraint coordinator reported that restraint use is also discussed monthly in the restraint meeting. This was confirmed in the meeting minutes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>



## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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>The service provides an environment that encourages good practice, which 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 have resulted in improvements to service provision. The projects include reviewing whether improvements have had positive impacts on resident safety or resident satisfaction.</p>	<p>A number of quality initiatives have been implemented with positive outcomes achieved. The service has embedded a welcoming and structured orientation process for new staff that ensures they feel welcomed, supported, confident and competent in their roles thus ensuring improved care for residents. The staff roster is stable and consistent so that residents and family get to know the staff and are very satisfied with the communication and care, as evidenced in the satisfaction survey results when comparing results between 2015 and 2016. Staff turnover has also declined. Completion rates of inductions have improved to 100%.</p> <p>The service has implemented an improvement project around palliative care which has seen an increase with family satisfaction with this aspect of care. The number of palliative care referrals has increased. Staff training on palliative care has resulted in staff feeling more confident and competent in caring for residents requiring palliative care. A palliative care kit has been organised for each family and has been well received with positive feedback.</p>

			Housekeeping standards were reviewed and new processes were embedded to improve levels of resident and family satisfaction with the housekeeping standards.
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	The service has implemented a project to improve and sustain resident satisfaction with the meals and the meal service.	<p>'Project delicious' was implemented to improve and sustain resident satisfaction with the food service. Staff were provided with education on all aspects of food safety and the dining experience with a focus on "it's more than it is what is on the plate". The menu was reviewed and the menu now provides residents with an alternative at each meal service.</p> <p>The activities staff decorate the dining room and the tables are set nicely to enhance the dining experience. The menu of the day is displayed on boards in the dining rooms.</p> <p>The residents are encouraged to provide feedback in the notebook in each dining area about their dining experience and the food provided. This feedback is reviewed daily by the village manager and the chef and trends are discussed at staff and resident meetings.</p> <p>Resident dietary needs are discussed at kitchen meetings to ensure all kitchen staff have relevant information about the resident's dietary needs.</p> <p>The resident and relative satisfaction survey results evidenced that there has been an improvement noted across all service levels from the previous year's result in relation to the food service. There has also been an increase in the positive comments noted in the food comment notebooks.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources,</p>	CI	The service identified the need to improve resident satisfaction with the Engage programme and increase involvement and attendance at activity sessions. The Engage programme was reviewed, to offer more variety and activities tailored to meet the needs of groups and individuals.	<p>The existing Engage programme was reviewed based on resident feedback and the programme was amended to include more involvement from the village residents as volunteers, the introduction of a men's club and a change to the hours' staff worked in the dementia units to provide a programme and support up until 6.30 pm.</p> <p>Staff were given training on the amended programme and on individual resident goal setting. The Engage calendar is displayed in</p>

<p>and interests) that are meaningful to the consumer.</p>			<p>each area. Staff are encouraged to take photos of residents attending the activities and copies of these are regularly sent to family members. The lounge activity programme for the hospital and care centre residents was reintroduced providing activities between 4 and 8 pm. The making memories programme with a focus on music and pet therapy was introduced. The SPCA regularly brings animals into each area and the dementia residents were supported to knit a blanket for the visiting dog.</p> <p>The Engage programme now includes more active activities for the residents including dance, cooking, gardening and quizzes. Evelyn Page has developed a village friends programme where by village volunteers spend time with the residents visiting and reading to them. The village friends also support the running of the 'blokes shed' and men's club. The village friends have a rapport with the residents and their families that strengthen the feeling of family and community. The village friends have a roster of volunteers available to provide companionship and reassurance for residents who are in palliative care and provide support for the families.</p> <p>The extension of the activity staff hours in the dementia units has seen a reduction in behaviours over this time and a reduction in the use of PRN medication. There has been an increase in resident satisfaction around activities, as evidenced in the February 2016 survey results and an increase in weekly attendance at the activities offered. Staff interviewed described an increase in resident engagement during the activities that are offered</p> <p>All residents and relatives interviewed on the day of audit confirmed their satisfaction with the activities and the one-on-one companionship provided to the residents.</p>
<p>Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes</p>	<p>CI</p>	<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 created a new laundry shift with the responsibility for labelling all resident personal items on admission and as required. All laundry staff received training on the new labelling machine and laundry</p>



<p>are monitored for effectiveness.</p>			<p>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 for 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 lost or 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 number of missing/lost items of personal clothing. Any lost items of laundry are now sent to the village manager who repatriates these to the owners. The village manager advised that they now only receive one to two items of lost clothing per fortnight. A visit to the laundry on the day of audit demonstrated evidence of the system being implemented with only one item of unnamed clothing and the process being implemented to rename this.</p>
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End of the report.