# Bruce McLaren Retirement Village Limited

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bruce McLaren Retirement Village Limited

**Premises audited:** Bruce McLaren Retirement Village Limited

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 11 May 2017 End date: 12 May 2017

**Proposed changes to current services (if any):** This audit has assessed the service appropriateness to provide medical level care under their current hospital certification

**Total beds occupied across all premises included in the audit on the first day of the audit:** 129

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

## General overview of the audit

Bruce McLaren is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia care level care for up to 158 residents. On the days of the audit, there were 129 residents, including three residents receiving rest home level of care in serviced apartments. The service is managed by a village manager who is supported by an assistant village manager and a clinical services manager. The residents and relatives interviewed spoke positively about the care and support provided.

This surveillance audit was conducted against a sub-set of 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.

Two of two findings from the previous audit around service delivery plans and medication management have now been met.

The service is to be commended on the achievement of continued improvement ratings around improvements implemented from analysis of clinical quality data, activities, restraint minimisation and infection surveillance.

This surveillance audit also included verifying the service for the provision medical level care under their current hospital certification.

## Consumer rights

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

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |  | Standards applicable to this service fully attained. |

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme continues to be implemented. 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 includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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

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. 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 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 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 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food 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. |  | Standards applicable to this service fully attained. |

There is a preventative and planned maintenance schedule in place. A current building warrant of fitness is posted in a visible location (expiry 14 October 2017).

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

Ryman Bruce McLaren has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using a restraint or an enabler.

## 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. |

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 3 | 13 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 37 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  There is a complaints’ register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner and timeframes are met. Two complaints have been lodged since January 2016 to date. There is evidence of complaints received being discussed in staff and management meetings. Complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The governing body, Ryman Healthcare Limited, has established systems in place that define the purpose, values, scope, direction and goals of the organisation and the facility and the monitoring and reporting processes against these systems. The service provides rest home, dementia care and hospital level care for up to 158 residents in a three-level building. There are 43 rest home/dual purpose beds on level 1, plus 30 rest home approved beds in serviced apartments, 44 hospital level beds (which are located on level 2) and 41 dementia level beds in 2 separate units (a 21-bed and a 20-bed unit) on level 3.  There were 129 residents in the facility on the day of audit. There were 37 rest home 9 including one rest home respite) and seven hospital residents on level one, and three rest home residents living in the serviced apartments. There were 44 hospital level residents on level two (including one resident’s admitted under an interim care contract) and 41 residents receiving specialist dementia services (including 1 resident on YPD contract). There were no residents on the day of audit admitted under other contracts.  Ryman Healthcare has an organisational total quality management plan in place. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the Team Ryman Programme.  The village manager (non-clinical) commenced employment in October 2016. He has previous health management experience in other fields of health and is supported by a clinical manager and an assistant village manager. The clinical manager has three years’ experience in aged care and was previously employed in the acute sector. The village manager, in consultation with the clinical manager, leads daily operation of the village. Coordinators, who are registered nurses, manage the rest home, hospital and dementia units and another coordinator manages the serviced apartments.  The management team is supported by the wider Ryman management team, which includes support from a regional manager.  The village manager and clinical manager have maintained at least eight hours to date of professional development activities related to managing a village. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Bruce McLaren has a well-established quality and risk management system that is directed by head office. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers (village manager, assistant village manager, clinical services manager/RN), the GP and staff (six caregivers, seven RNs- including three unit coordinators, one health and safety officer, and three activity coordinators) and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.  Resident meetings are held two-monthly. Relative meetings are held six-monthly. Minutes are maintained. Annual resident and relative surveys are completed annually. An annual resident satisfaction survey was completed in March 2017, followed by a relative survey and the results showed the overall resident and relative experience was reported as being good or very good. Action plans are completed with evidence that suggestions and concerns are addressed.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly Team Ryman process. They are communicated to staff as evidenced in staff meeting minutes.  Team Ryman prescribes the annual internal audit schedule that was being adhered to. Audit summaries and quality improvement plans are completed where a non-compliance is identified. Issues and outcomes are reported to the appropriate committee (e.g., health and safety). Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.  Monthly clinical indicator data are collated across all areas. There is evidence of trending of clinical data and development of quality improvement plans when results do not meet expectations. The quality system includes the monitoring of adverse events, consumer complaints, infection prevention and control, health and safety and restraint management. The combined Health and Safety and Infection Prevention and Control Committee meet bi-monthly and include discussion of all incidents/accidents and infections. There was a current hazard register in place. Management reports progress to head office staff at least monthly, against the quality and risk management plan and quality improvement initiatives.  The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems are developed, implemented and regularly reviewed for the sector standards and contractual requirements.  The service has implemented a falls reduction project which has resulted in a significant sustained reduction in falls.  Health and safety policies are implemented and monitored by the two-monthly Health and Safety Committee meetings that also include review of infection control and of incidents. 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. Bruce McLaren has achieved tertiary level ACC Workplace Safety Management Practice. The hazard identification resolution plan is sent to head office and documents any key hazards that are identified. A review of the hazard register and the maintenance register indicates there is resolution of issues identified. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | 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. Ten accident and incident reports were reviewed.  A review of incident/accident forms for the facility identifies that all are fully completed and include timely follow up by a registered nurse. The managers are involved in the adverse event process with regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.  The village manager is able to identify significant events that would be reported to statutory authorities. There have been four notifications including one infection outbreak in November 2016 that was controlled and well managed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (three caregivers, three registered nurses(one a unit coordinator), two activities staff, one chef, one laundry/housekeeper, one clinical manager, one assistant village manager, one maintenance and one gardener), included a signed contract, job description ,police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.  A register of registered nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.  A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Nineteen care assistants work in the dementia unit. All have completed the dementia units.  Registered nurses are supported to maintain their professional competency. Thirteen of twenty one registered nurses have completed their InterRAI training, meeting contractual requirements. Staff competencies are completed as relevant to the role. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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. In the hospital there is a hospital coordinator (RN) 40 hours per week and two additional RNs on morning duty. There are two RNs in the unit on pm duty and one RN on nights covering the three levels within the facility. The RN on night does not leave the building to attend village residents. During the day there is dedicated serviced apartment staff cover. From evening and through the night, cover is provided by the hospital unit (on day of audit there were three rest home level residents requiring care in apartments).  In the special care unit/s there is an RN unit coordinator who works 40 hours per week with days off being covered by another RN. There is a second RN on morning duty each day along with an RN in the unit/s on afternoon duty.  In the rest home, there is a unit coordinator (RN) 40 hours per week with days off being covered by an additional RN.  Staff on duty on the days of the audit were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | 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 pharmacy. All medications were securely and appropriately stored on day of audit. There are weekly and six-monthly controlled drug checks.  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.  Fourteen medication charts were reviewed (four rest home, six hospital and four dementia). The service uses an electronic medication management system. All medication charts reviewed have ‘as needed’ medications prescribed with an individualised indication for use. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly. The medication folders include a list of specimen signatures.  The GP and dementia unit coordinator regularly review the use of antipsychotic medication in use and where required, make referrals to the Community Mental Health Team and or psychogeriatrician for a review.  Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents at the time of audit.  The medication fridge temperatures are recorded weekly and these are within acceptable ranges.  There is a signed agreement with the pharmacy. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service employs a qualified chef manager, to oversee the food service. The chef manager is supported by two cook assistants and two kitchen assistants daily, to prepare and provide all meals on-site. A four-weekly seasonal menu had been designed and reviewed by a dietitian at organisational level. The service has implemented the Ryman project delicious which provides residents with a choice of meals at lunch and dinner time. The dining experience has also been enhanced with the introduction of music at meal times. This project has resulted in a reduction in the number of residents losing weight and an increase in the residents with weight gain.  The chef receives a resident dietary profile for all new admissions and is notified of dietary changes. Soft/pureed and diabetic desserts and alternative foods for known dislikes are provided. Food is delivered in hot boxes to each kitchenette and served from bain-maries by the care staff. Staff were observed sitting with the residents and assisting them with meals. Staff interviewed state there are nutritious snacks available 24 hours in the dementia care units. Adequate snacks were sighted in the kitchenette fridges and cupboards.  The kitchen is well equipped. The chiller temperature is checked twice daily. Fridge and freezer temperatures are checked and recorded daily in the main kitchen and kitchenettes. End cooked food temperatures are monitored. All foods were date labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals were stored safely in the kitchen.  Staff have been trained in safe food handling and chemical safety. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Communication to the GP for a residents' change in health status were 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.  Wound assessments, treatment and evaluations were in place for all current wounds. There are three residents with facility acquired (two stage II resolving to stage I and one stage I) and two residents with non-facility acquired (one unstageable and one stage II) 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 site and supports the work completed by the on-site registered nurses. Staff receive regular education on wound management.  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.  Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | Three activity coordinators implement a separate activity programme for the rest home, hospital, village and dementia units. The Ryman ‘Engage’ core programme is currently delivered Monday to Friday across these areas. There are two activity coordinators (one DT trained and one in training for DT) providing activities in the dementia unit over a six-day week from 9 am – 6 pm. All activity team members have a current first aid certificate.  The Engage programme has set 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. Time is spent with residents and relatives to further explore their individual life goals and to aid development of these new and meaningful activities. Residents in the dementia care unit were observed being fully engaged in the activity provided. There were 24-hour activity care plans documented in the two dementia resident files sampled. Family and staff interviewed in the dementia unit advised that the residents are frequently taken on walks outside in the grounds of the village and on van outings which are arranged weekly. Music and pet therapy is offered.  Activities were observed to be delivered simultaneously in the rest home, hospital and dementia unit. There was a vibrant craft market displaying crafts (made by residents and staff) observed on the day of audit with people from the community in attendance. All residents in the village and care centre may choose to attend any of the programmes offered. Residents in the dementia unit are also accompanied to attend activities offered in the rest home. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There 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 companionship offered to those less independent residents. Sunshine ladies (residents) run the village shop and take the shop to the hospital residents.  There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events.  Resident meetings were held bi-monthly and open to families to attend.  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. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | 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, allied health, wound care nurse, 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. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 14 October 2017). |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | The surveillance programme is organised and promoted via the Ryman calendar. The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections are in place and appropriate to the complexity of the service provided. Effective monitoring is the responsibility of the infection control officer who is the clinical manager. An individual infection report is completed electronically 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. Six-monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Bruce McLaren include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and infection rates have been low.  The service identified that the UTI rate was above an acceptable benchmark in September 2015 and implemented a project to address this. This sustained project has resulted in low UTI rates per 1000 bed days.  There has been one outbreak in November 2016 in the dementia unit, which was contained and well managed. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | CI | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service has been restraint-free since it opened in December 2014. There were no enablers in use.  The restraint coordinator (clinical manager) attends six-monthly Ryman restraint approval committee meetings. The use of enablers/restraint is discussed at clinical meetings and RAP meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Clinical Indicator data is collected each month for the following: infections and incidents (including falls); pressure injuries; bruising; challenging behaviour; medication errors; and staff incidents. Accident and incident forms are completed by staff and collated. The clinical manager analyses and trends the data and communicates the results to all staff at staff meetings and places the graphed information on the staff noticeboards. Where the data identifies an area which are above an acceptable benchmark, the clinical manager implements a corrective action. The incidence of falls was noted to be above an acceptable benchmark in November 2015 and a focused and sustained falls reduction project was implemented. | Analysis of the falls data in November 2015 evidenced that the number of falls occurring across all service levels was above an acceptable benchmark. The service initiated a project to reduce the number of falls. Sensor mats and pendant call bells were provided to at risk residents. A falls clock was commenced and an alert system (a decorative flower on the resident’s door) was used to alert all staff to at risk residents. Each staff member is required to take responsibility for pre-empting and reducing falls. Intentional rounding was introduced and staff had to document what the resident was doing at the time of the staff observation. Care plans were amended to include falls prevention strategies and the residents were toileted more frequently. Toolbox talks were regularly provided to staff on the importance of observing the residents at risk of falling. A much focused analysis of the causative factors for any resident who fell was completed by the clinical manager at the time the incident was reported. The GP was asked to review the medication for all frequent fallers and a polypharmacy clinic was established that meets bi-monthly. Actions have continued through 2016, and as a result of these actions, the falls rate reduced from 11 per 1000 bed days in November 2015 to 4.1 per 1000 bed days in April 2017. Bruce McLaren currently has the lowest rate of falls across the Ryman Group. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The service identified the need to improve resident satisfaction with introduction of new resident driven activities and increase overall individual satisfaction and attendance at activities. | The existing Engage Programme is based on resident feedback and the programme was amended to include space to allow introduction of new resident driven activities. Staff were given training on the amended Engage Programme and individual resident goal setting. The Engage calendar is displayed in each area. Time is spent with residents to further explore their individual life goals. Staff are encouraged to take photos of residents attending the activities and copies of these are regularly sent to family members. Garden projects were introduced with each resident growing their own tomatoes. Pet therapy was introduced with a monthly pet day offered. The pet owners bring many different animals into each area and the residents and relatives interviewed stated they all looked forward to this day. A new exercise ‘Zumba Gold’ class, line dancing and table tennis competition has been introduced and now become part of the ongoing Engage Programme. The Bruce McLaren choir was formed in April 2017 with both residents and staff participating.  Staff have noted a reduction in challenging behaviours over this time. There has been an increase in resident satisfaction around activities, as evidenced in the resident/relative survey results (March/April 2017) and an increase in weekly attendance at the activities offered. Staff interviewed described an increase in resident engagement during the activities that are offered.  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. |
| Criterion 3.5.7  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. | CI | The service noted in September 2015 that the incidence of urinary tract infections was above an acceptable benchmark across all care levels. The service implemented a project to reduce the incidence of urinary tract infections and the improvements made since the initiative were implemented have been sustained. | Analysis of the surveillance data identified that the incidence of UTI rate was above an acceptable benchmark. The service initiated a project to reduce the incidence of UTI infections. This project included providing education to staff and residents on the prevention and management of UTI infections and on nutrition and hydration. At risk residents are discussed intensively at all handovers and all at risk and hospital level residents are placed on fluid monitoring. Increased fluids are offered to all residents with the introduction of ice cream, ice block and smoothie rounds in the summer months. Residents with a UTI are discussed at all clinical and staff meetings. The GP is consulted about the management of all residents with chronic UTI’s.  This sustained initiative has resulted in a continued reduction of UTIs from an average across all units of 5.3 UTIs per 1000 bed days, to 1.3 per 1000 bed days in April 2017. |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | CI | Ryman Bruce McLaren has demonstrated a commitment to promoting and maintaining independence for all residents. The overall care philosophy at Bruce McLaren does not include the use of any form of restraint. Staff have been provided with education and support to reduce the incidence of challenging behaviours and the need for the use of restraint. | The care philosophy in use at Bruce McLaren does not include the use of any form of restraint. Staff are provided with education at induction on the management of challenging behaviours and restraint minimisation practices.  Time is spent at each handover with the care teams reviewing any resident concerns and then developing care strategies to decrease the potential for any incidents to escalate. Staff are assigned intentional rounding responsibilities and are required to document where and what the residents are doing during this observation. This information is reviewed during each the shift by the registered nurse. Residents are toileted frequently and restless residents are distracted with activities. Engaging activities are provided in the resident lounges by the activity team.  There are weekly meetings with the unit coordinators and registered nurses to discuss any residents of concern. The GP, psychogeriatrician and MHSOP team are consulted regularly regarding the care and management of residents with challenging behaviours. A family support group was set up for the families of residents in the special care units with a focus on supporting staff and families with de-escalating challenging behaviours. Families interviewed confirmed that they found these support groups very beneficial.  Additional sensor mats have been purchased for use by restless residents and residents who have been identified as a high falls risk. Staff have been provided with regular ongoing education on elder abuse and neglect, dementia and the management of challenging behaviour.  The outcomes of these combined initiatives have been that service has been restraint and enabler free since opening in 2014 and the incidence of challenging behaviours has remained low compared to other Ryman facilities, since May 2016. |

End of the report.