

# Edmund Hillary Retirement Village Limited - Edmund Hillary Retirement Village

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## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Edmund Hillary Retirement Village Limited
<b>Premises audited:</b>	Edmund Hillary 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: 6 June 2017    End date: 7 June 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	185



# 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
	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

Ryman Edmund Hillary provides rest home, hospital and dementia level care for up to 235 residents and on the day of the audit there were 185 residents. The service is managed by a village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced 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, family, management and staff.

The service continues to maintain a comprehensive quality and risk management programme.

There are two areas of continuous improvement awarded around their quality systems and the staff orientation programme.

## 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.		Standards applicable to this service fully attained.
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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

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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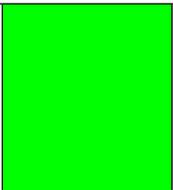
The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and health care assistants responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three monthly by the GP.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families report satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were five residents with restraint and six residents with enablers at the time of audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs and a six-monthly comparative summary is completed.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	2	37	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 1.1.13: 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. Complaint forms are available throughout the facility. Information about complaints is provided on admission. Interviews with all nine residents (three rest home including two in a serviced apartment, and six hospital) and family confirmed their understanding of the complaints process. Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.</p> <p>Interviews with managers (village manager, assistant village manager, clinical manager) and staff (health care assistants and registered nurses (RNs), activities coordinators, head chef) confirmed their understanding around the processes implemented for reporting and managing complaints.</p> <p>There is a complaint 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.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<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 for that are 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.</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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 arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All five family interviewed (three dementia level, one hospital level and one rest home level) stated they are well-informed. Ten incident/accident forms and corresponding residents' files were reviewed and all identified that either the next of kin were contacted or requested not to be contacted (minor events only). Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Interpreter services are available if needed for residents who are unable to speak or understand English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Edmund Hillary is a Ryman healthcare retirement village. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. The service is certified to provide rest home, hospital and dementia levels of care for up to 235 residents. This includes 40 serviced apartments certified to be able to provide rest home level care, 50 rest home level beds, 115 hospital level beds, and 20 dementia level beds. Fifty-two beds are dual-purpose. There were 64 rest home level residents (including nine in the serviced departments), 112 hospital level residents and 20 dementia level residents living at the facility during the audit. The service holds the aged related residential care (ARRC) contract, respite contract and the long-term chronic conditions (LTCC) contract. There were two hospital level residents on respite during the audit and none on the LTCC contract.</p> <p>There is a documented service philosophy set at head office that guides quality improvement and risk management in the service. Specific values have been determined for the facility. Organisational objectives for 2017 are defined with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2017 objectives.</p> <p>The village manager at Edmund Hillary has been in the role since 2013 and has a background in retail management. An assistant manager carries out administrative functions and a clinical services manager (registered nurse) oversees clinical services. The management team is supported by the wider Ryman management team that includes a regional manager. The village manager and clinical services manager have maintained at least eight hours of professional development activities relating to managing a village.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>Edmund Hillary continues to implement an established quality and risk management system that is directed by head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the managers (village manager, assistant village manager, clinical services manager/RN), the GP, staff (ten healthcare assistants (HCAs), nine RNs, two cooks, seven activities staff) and review of</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>management and staff meeting minutes demonstrates the staff's involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly in the rest home and in the hospital. Relative meetings are held six-monthly. Minutes are maintained. Annual resident and relative surveys are completed annually. Action plans are completed with evidence that suggestions and concerns are addressed in a timely manner. Staff are kept informed regarding survey results and improvements identified.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly Team Ryman meetings. They are communicated to staff, 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. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The internal audit programme is being completed as per the annual schedule.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Quality improvement plans (QIPs) are implemented where opportunities for improvements are identified. The 2017 QIP register has 11 quality initiatives documented (one February, two March, one April, seven May). One of the eleven quality initiatives has been signed off as completed. The remaining ten initiatives are currently being actioned. The managers' report that two recent Norovirus outbreaks have prevented staff from actively working on their 2017 QIPs. All 15 QIPs for 2016 are signed off as completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings that also include review of infection control and of incidents. A hazard identification resolution plan is sent to head office and identifies any key hazards that are recognized. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified. There were no staff off work from a work-related accident. A particular focus is on manual handling training of staff, which begins during their orientation.</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Falls remain at low levels with initiatives implemented promptly where there is a spike in reported falls.</p>
<p>Standard 1.2.4: Adverse Event</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</p>

<p>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>completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms for the facility identifies that all are fully completed and include follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.</p> <p>The village manager interviewed could identify situations that require reporting to statutory authorities including instances where a Section 31 report is required. The public health authorities were promptly notified following three recent outbreaks in 2017 (one gastro and two norovirus).</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. Nine staff files reviewed (four healthcare assistants, three registered nurses, one cook, one kitchen assistant) included an application form and reference checks, signed employment contract, a job description relevant to the role the staff member was in, police checks, and evidence of completed general and job-specific induction programmes. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of registered nurse practising certificates is maintained within the facility. Practicing 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.</p> <p>There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Thirteen of thirty-two registered nurses have completed their InterRAI training and two are currently in training. Staff training records are maintained. Ten HCAs work in the dementia unit. Eight have completed their dementia qualification and the remaining two staff have been employed for less than one year. There are implemented competencies for registered nurses and healthcare assistants related to specialised procedure or treatment including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>to residents. Rosters implement the staffing rationale.</p> <p>There are six full-time coordinators/RNs, one for each designated unit (three hospital units, one rest home unit, one dementia (special care) unit and one for the serviced apartments). Staffing throughout the facility meets contractual requirements and is adjusted based on the number of residents and their acuity. The serviced apartments are staffed with an RN five days a week and an EN two days a week with three HCAs during the PM shift and one HCA during the night shift. There is a minimum of three RNs (one for each hospital unit) and eleven HCAs on site during the night shift.</p> <p>Activities staff are provided seven days a week in each hospital unit and the dementia unit and five days a week for the rest home and the serviced apartment residents. One activities coordinator and one activity assistant is rostered for each unit, which includes the serviced apartments.</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 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders.</p> <p>The facility uses an 'Alpaca' pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses who have passed their medication competency administer medications in the hospital. Registered nurses and senior healthcare assistants who have passed their medication competency administer medications in the rest home and dementia unit. Medication competencies are updated annually and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on an electronic administration signing system. Controlled drugs are checked out by two people. The DDA register is checked weekly.</p> <p>Eighteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. As required medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>The service has two cooks who between them cover all shifts and days. There are also two kitchen hands. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from a bain-</p>

<p>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>marie in all dining rooms. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked at all meals. These were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is approved by a dietitian. All resident/families interviewed were satisfied with the meals. Additional snacks are available at all times in the dementia unit.</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 changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All eight long-term care plans sampled have interventions documented to support current needs. Care plans have been updated as residents' needs changed. The respite resident has an initial care plan documented.</p> <p>Resident falls are reported on accident forms (on VCare) and written in the progress notes.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds (on VCare). Wound monitoring occurs as planned. There are currently four wounds in the rest home (two chronic lesions and two skin tears). There are currently eighteen wounds in the hospital (eleven skin tears, six lesions and one haematoma). There are currently three wounds in the dementia unit (three skin tears). All wounds are seen by the wound care nurse weekly. Some wounds have had input from the GP and wound care specialist.</p> <p>There is currently a high number of pressure injuries in the hospital. The wound care nurse is aware of this and has formed a pressure injury prevention team which is responsible for monitoring and education. They are already seeing a reduction in pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>FA</p>	<p>There is an activities coordinator on each unit and they work 32.5 hours weekly. Four of the activities coordinators are registered diversional therapists. Each unit also has an activities assistant for 2.5 hours a day. On the days of audit residents were observed participating in exercises, playing bingo, listening to music and enjoying entertainers.</p> <p>There is a weekly programme in large print on noticeboards in all areas and a computerised noticeboard in the</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>foyer. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, knitting, walks outside, crafts, games and quizzes.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are weekly church services, interdenominational on a Thursday and Catholic on a Sunday.</p> <p>Each unit has at least one van outing weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated.</p> <p>Some residents attend Communicare and there are visiting community groups such as choirs, children's groups and pet therapy.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held bi-monthly and are open for families to attend.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The eight long-term care plans reviewed have been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each resident and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home and dementia residents and one monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry 13 August 2017).</p>

for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the quality coordinator (registered nurse) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations are available on the staff noticeboard in each area. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>The service had three outbreaks from January to May 2016 in dementia care and hospital areas. Relevant authorities were notified and documentation completed on a daily basis. Staff were kept informed at handovers and by memos. Education sessions were increased. All staff received an educational debrief.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are 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 five residents with restraint and six using enablers.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</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

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
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	A range of data is collected across the service using an electronic data system. Data is collated and analysed with comprehensive evaluation reports completed six monthly. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., Team Ryan management meetings, full facility meetings, RN meetings). Templates for all meeting document action required, timeframe, and the status of the actions.	<p>Examples were provided during the audit to reflect quality initiatives, which were identified via trends in data. The time for staff to respond to call bells is better than the Ryman acceptable standard with the Ryman average response time to answer a call bell at 1.1 minutes and Edmund Hillary’s average time to respond at .7 minutes. The action plan that has been implemented includes discussions in various staff meetings, in-service training, allocation of specific staff to be responsible for responding to call bells during meal times and during handover, and senior staff spending more time on the units during busy periods to motivate staff to answer calls bells. Residents' who use their call bell frequently, are transferred closer to the nursing station for closer supervision, and intentional rounding is implemented for these residents.</p> <p>Comprehensive data analysis and trending has also been undertaken relating to the number of residents falls. Falls prevention strategies include intensive staff training programmes to increase staff awareness, intentional rounding for residents at risk of falling, implementation of a traffic light indicator programme to alert staff to residents at risk of falling, identification of times during the day where residents are at greater risk of falling (falls clocks), and early (proactive) GP/nurse</p>

			practitioner involvement. Physiotherapy assessments are completed by a qualified physiotherapist and regular physiotherapy treatments are provided by a physiotherapy assistant. The number of falls continues to decline when analysing data from August 2016 (79 falls) to an average of 58 falls per month (March – May 2017). QIPs are implemented in a timely manner when there is a random spike in the number of falls. A root cause analysis (RCA) is completed for every fall that results in a fracture.
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	A comprehensive orientation programme has been implemented for new staff.	<p>A previous area identified for improvement related to ensuring new staff feel welcomed to the team, and confident and competent at the end of their orientation period. Issues had arisen previously around staff not completing their orientation. Actions taken included the development of a revised orientation pack for all new staff, designation of orientation 'buddies' within all departments to ensure there is continual support and guidance for all new staff, provision of education and training for the buddies on the expectations of their roles, and the development of an orientation plan for the orientation period. The percentage of staff completing their orientation programme has increased from 77% (1 February 2015) to 100% at the end of 2016 and 97% at the end of May 2017. Feedback from staff via staff surveys on the usefulness of their orientation is positive. They report that they feel confident and competent to undertake their role. Furthermore, comments around the length of orientation time is taken into consideration for each employee based on their level of skill and confidence in their role and is adjusted as required from three to five days.</p>

End of the report.