

Kiri Te Kanawa Retirement Village Limited - Kiri Te Kanawa Retirement Village

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| Legal entity: | Kiri Te Kanawa Retirement Village Limited |
| Premises audited: | Kiri Te Kanawa Retirement Village |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 9 August 2017 End date: 10 August 2017 |
| Proposed changes to current services (if any): | |

Total beds occupied across all premises included in the audit on the first day of the audit: 97

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

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

General overview of the audit

Ryman Kiri Te Kanawa provides rest home, hospital and dementia level of care for up to 127 residents. There were 97 residents at the time of the audit.

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, interviews with residents, family, management, staff, a general practitioner and a nurse 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. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There are six areas of continuous improvement awarded around services for Māori residents, corrective actions plans, improving meal options, management of an external disaster, restraint minimisation and infection control.

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. |
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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 and implemented Māori Health plan in place. Individual care plans reflect the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when 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 implemented for the management of complaints.

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. |
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for 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 for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. 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

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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. |  | Standards applicable to this service fully attained. |
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed, confirm they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provides a varied and interesting activities programme for each resident group. The engage programme meets the abilities and recreational needs of the group of residents including outings and entertainment.

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

The menu is designed by a dietitian at an organisational level and provides a range of dietary options that ensures individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours.

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. |
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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 are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible.

There are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | All standards applicable to this service fully attained with some standards exceeded. |
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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 no residents with restraint and six residents with enablers during the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

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. | | 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 and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. There have been no outbreaks in the care centre.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 1 | 44 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 6 | 87 | 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) |
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| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one village manager, one assistant manager, one clinical manager) and sixteen care staff (two staff registered nurses (RNs), one hospital coordinator/RN, one rest home coordinator/RN, one serviced apartment coordinator/senior caregiver, eight staff caregivers, three activities coordinators) 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 give informed consent.</p> | FA | <p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in ten resident files (four hospital [including one respite resident and one resident under long-term chronic health condition contract-LTCHC], four rest home and two dementia care) were signed by the resident or their enduring power of attorney (EPOA). Written consents were sighted for specific procedures.</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the resident's file where required. Caregivers and registered nurses (RN)</p> |

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| | | <p>interviewed confirmed verbal consent is obtained when delivering care. Discussions with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Nine resident files of long-term residents have signed admission agreements and the respite care resident has a signed a short-term agreement.</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 residents' 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. 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 available and located in a visible location. 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 complaint's 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. Nine complaints received in 2016 and two complaints received in 2017 (year to date) have been managed in a timely manner and are documented as resolved. 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>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. Twelve relatives (five rest home, three hospital and four dementia) and ten residents (five rest home with one in a serviced apartment, five</p> |

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| rights. | | hospital) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The managers 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 staff were assisting with resident care. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into residents' care. 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 district health board contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement in assessment, 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 a comprehensive manner. There were 16 residents who identified as Māori at the time of the audit. They are given a choice whether or not they would like to have a Māori care plan developed. The service has achieved a continuous improvement in relation to Māori health and beliefs. |
| 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 multi-disciplinary 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 their cultural values into account. |

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| <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>FA</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 (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. 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 for 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. Fifteen 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> <p>Access to interpreter services is available if needed, for residents who are unable to speak or understand English. There was one resident with English as their second language. Family and staff</p> |

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| | | are able to interpret. The resident and family were not available to be interviewed. |
| <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>Kiri Te Kanawa is a Ryman Healthcare retirement village located in Gisborne. They are certified to provide rest home, hospital and dementia levels of care in their care centre for up to 97 residents. There are also 30 serviced apartments that are certified to provide rest home level care. In the care centre, there are 81 dual-purpose (rest home/hospital) beds and sixteen beds are available in the secure unit for dementia level of care.</p> <p>Occupancy during the audit was 43 rest home, 36 hospital and 15 dementia level residents in the care facility. There were three rest home level residents in the serviced apartments. The care centre is certified for medical. There were five residents on respite (one hospital, four rest home) and three residents on the long-term conditions contract (one rest home, two hospital).</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2017 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been in his role for three years. He holds over 30 years' experience in business leadership roles and has attended over eight hours annually of professional development activities relating to managing a retirement village. The village manager 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 provided from the regional manager.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p> | FA | <p>Ryman Kiri Te Kanawa has an 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 staff (sixteen care staff, one head chef, one head maintenance, two cleaners, one laundry), and review of management</p> |

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| <p>maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>and staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</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. 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. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and displayed in the staff room, showing trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Health and safety policies are implemented and monitored. One health and safety officer (caregiver) and one health and safety representative (caregiver) were interviewed. Both individuals have completed external health and safety training. Health and safety meetings are conducted two-monthly. 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 2018).</p> <p>The service has achieved a continuous improvement in relation to the results achieved from corrective action plans that were implemented to reduce the number of residents' falls and incidents of challenging behaviours.</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</p> |

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| <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>incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of 15 incident/accident forms for 2017 identified that all are fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur. Neurological observations are completed if there is a suspected injury to the head.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. A section 31 report was sighted for a coroner's inquest that is now closed (24 July 2016).</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. Eleven staff files reviewed (one maintenance, two housekeepers, one activities coordinator, two unit coordinators/RNs, one staff RN, four caregivers) included a signed contract, job description relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included 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>The orientation 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. Staff training records are maintained. 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. Seven of fourteen registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Eleven of twelve caregivers who work in the dementia unit either have completed their dementia qualification (nine caregivers) or have completed their papers and are awaiting their assessments (two caregivers). One caregiver has been employed for less than one year in the dementia unit and is in the process of completing her qualification.</p> |

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| <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> | <p>FA</p> | <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.</p> <p>The facility covers three floors with elevators in strategic locations. The clinical manager is an experienced registered nurse with a current practising certificate who works full-time Monday – Friday.</p> <p>There are thirty serviced apartments certified to provide rest home level of care that cover three floors. The serviced apartment coordinator/senior caregiver trained as an enrolled nurse and works Sunday – Thursday. The AM shift is staffed with three caregivers, PM two caregivers and night shift is covered by the caregivers on the first level of the care centre who are caring for rest home level residents. Staff communicate via mobile telecommunications.</p> <p>Nineteen rest home only, thirty hospital only and twenty dual-purpose beds are located on the ground floor. Staffing includes a hospital unit coordinator/RN (Tuesday – Saturday) and a rest home unit coordinator/RN (Sunday – Thursday). This is in addition to two staff RNs who are assigned to cover hospital level residents on the AM and PM shifts. The night shift is staffed with one RN and five caregivers.</p> <p>The first level includes the secure dementia unit and twelve rest home level beds. Both areas are staffed with adequate numbers of caregivers. The hospital unit coordinator/RN provides oversight for the dementia unit and the rest home unit coordinator/RN provides oversight for the rest home level residents.</p> <p>Extra staff can be called on for increased resident requirements. A cover pool has recently been implemented whereby (extra) care staff are scheduled to work Friday – Monday to cover absences. These assigned staff (two caregivers from 7am – 1pm and one RN from 7am – 3.30pm) work regardless if staff are absent. Additional casual staff are available if needed. The clinical manager reported that the cover pool is a recent quality initiative that is proving to be very successful.</p> <p>Activities staff are scheduled seven days a week in the hospital and dementia units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered.</p> <p>Staff on the floor on the days of the audit, were visible and were 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 reported that there are adequate staff numbers to attend to residents.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> | <p>FA</p> | <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. Personal resident information is kept confidential and cannot be viewed by other residents or members</p> |

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| <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | | <p>of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration.</p> |
| <p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p> | <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. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term and short-term care.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p> |
| <p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation is completed by the RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all the units. Medication fridges were monitored weekly and all temperatures were within the acceptable range. There were no expired medications. All eye drops and creams were dated on opening. There were three rest home residents who had been assessed by the RN and GP as competent to self-administer inhalers.</p> <p>Twenty medication charts (eight rest home, eight hospital four dementia care) were reviewed on the electronic medication system. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications is entered into the electronic medication system. Medication charts had been reviewed at least three-monthly.</p> |

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| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>All food and baking is prepared and cooked on-site. The head chef is supported by a second chef, cooks and kitchen assistants. All staff have been trained in food safety and chemical safety. The service has implemented an organisational initiative "Project Delicious" that has been designed to provide a choice of meals and meet all resident nutritional requirements. Food is delivered in hot boxes to the units, where they are served from bain maries in the satellite kitchens.</p> <p>The chef is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident dislikes and dietary preferences are documented on the weekly menu planner. Modified diets such pureed/soft foods are provided.</p> <p>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 daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received through direct feedback, resident meetings, surveys and audits.</p> <p>The service has achieved a continuous improvement in relation to improving meal services.</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 reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</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>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 that were reflected in the care plans were reviewed. Additional assessments such as behavioural, wound and restraints were completed according to need. Assessed needs and supports required were described in care plans.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated,</p> | <p>FA</p> | <p>Care plans reviewed demonstrated service integration and input from allied health. Residents' care plans were resident-centred. Support needs and interventions were documented to reflect the resident goals and the resident's current health status. Family members interviewed confirmed care</p> |

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| and promote continuity of service delivery. | | delivery and support by staff is consistent with their expectations. Residents (if appropriate) and family stated they were involved in the care planning and review process. Behaviour management including triggers, interventions and successful de-escalation techniques were included in the long-term care plan in two of the two dementia care resident files reviewed. |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place for residents with wounds (skin tears, chronic ulcer, three facility acquired stage two pressure injuries and one community acquired unstageable pressure injury). The hospital unit coordinator is the wound champion who is involved in the management of complex wounds and pressure injuries. There is access to a wound nurse specialist at the DHB. Adequate dressing supplies were sighted in the treatment rooms.</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 RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>There is a team of activity coordinators (including activity assistants) to coordinate and implement the engage programme in each of the units. Each unit has a separate programme with some integrated activities open to other groups of residents as appropriate. The hospital and rest home activity coordinators are progressing through the diversional therapy qualifications. The dementia care unit activity coordinator has completed the dementia unit standards. The three activity coordinators have a current first aid certificate. The programme is seven days a week in the hospital and dementia care unit and Monday to Friday in the rest home.</p> <p>The engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group such as triple A exercises. Rest home residents in the serviced apartments attend either the serviced apartment programme or rest home programme.</p> |

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| | | <p>There are adequate resources available. One-on-one time is spent with residents who are unable to participate or choose not to be involved in the activity programme. Special events and theme days are celebrated. Volunteers are involved in the activity programme such as piano playing. The service has a musical therapist, entertainers, choirs and canine therapy visits. Pre-school children and Plunket babies visit regularly. Community links include RSA lunches, Cosmopolitan club events and functions, Salvation Army and attending country music clubs.</p> <p>All residents have the opportunity to go on outings and a taxi van is hired for hospital residents in wheelchairs. There are twice weekly outings for dementia care residents and daily walks outside (weather permitting).</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>Eight of ten care plans had been evaluated by registered nurses' six monthly. One resident had not been at the service six months (rest home) and one resident was for respite care. Written evaluations describe the resident's progress against the resident's identified goals. Changes to care are updated on the long-term care plan. The multidisciplinary (MDT) review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. The family are invited to attend the MDT review and notified of the outcome if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been 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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | <p>FA</p> | <p>Referral to other health and disability services is evident in the residents' files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. There was evidence sighted of a resident's condition that had changed and the resident was referred for reassessment for a higher level of care. Discussions with the clinical manager and RNs identified that the service has access to a wide range of support through the GP, Ryman specialists, nurse specialists, hospice and contracted allied health services.</p> |

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| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <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 datasheets and product use information was readily available. Staff have attended chemical safety training.</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> | FA | <p>The building has a warrant of fitness that expires 26 June 2018. The facility employs a full-time maintenance person who is a qualified electrician. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule. Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration has been completed. Hot water temperatures in resident areas are monitored three-monthly. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>The dementia unit on the second floor has an outdoor balcony deck with raised gardens, seating and shade.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>All bedrooms in the rest home, hospital and dementia unit are single occupancy and have full ensembles. Fittings and fixtures are made of easy clean surfaces that meet infection control practice. There are 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> |

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| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>All resident's rooms were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. Residents are encouraged to personalise their bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>The dementia care unit, rest home and hospital units have a main lounge and family lounge. The large main lounges have seating placed to allow for individual or group activities. The dining room in each unit is spacious. The communal areas are easily accessible for residents using mobility aids or staff assistance.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits are completed as per the Ryman programme. There are dedicated cleaning and laundry persons on duty each day. All personal clothing and linen is laundered on-site. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals. The chemical provider monitors the use of chemicals and laundry processes. The cleaning trolleys are kept in locked areas when not in use.</p> <p>Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The service provides a clothes labelling service for residents.</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 first aid trained staff member on every shift. The village has an approved fire evacuation plan and fire drills take place six monthly. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities are in place. There are civil defence kits in the facility and adequate water storage on-site. The facility has a diesel-powered generator that proved to be very useful during</p> |

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| | | <p>a recent power outage.</p> <p>The call-bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms. The call-bell system is linked to staff pagers and to the call-bell panels in the rest home. Residents can choose to wear an alarm pendant.</p> <p>Staff confirmed that they conduct security checks at night.</p> <p>The service has achieved a continuous improvement in relation to management of civil defence.</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. All rooms have external windows with plenty of natural sunlight.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control committee is combined with the health and safety committee, which meets bi-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is sent out annually from head office and directed via the quality programme. The programme is reviewed annually at head office. A six-month analysis is completed and reported to the governing body. The clinical manager is the infection control officer with a job description outlining the responsibilities for infection prevention and control at the facility.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers and infection control signage 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), is made up of a cross-section of staff from areas of the service. The infection control officer has completed infection control and prevention training through video conference with an infection control specialist. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, local laboratory, infection control consultants and expertise from within the organisation.</p> |

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| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | <p>FA</p> | <p>The comprehensive infection prevention and control policies are currently under review at head office. Existing policies reflect the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. Policies are readily accessible to staff.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions and training is provided both at orientation and as part of the annual training schedule. Hand hygiene competencies are completed. 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 policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections, and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officers complete a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. The service has reduced urinary tract infections in the rest home. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks in the care facility.</p> <p>The service has achieved a continuous improvement in relation to the reduction of urinary tract infections.</p> |

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| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>CI</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 no 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

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.

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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 |
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| Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs. | CI | Māori residents' specific and identified cultural needs are documented in their Māori care plan. This cultural care plan provides specific instructions for staff to follow. Evidence was sighted to confirm that Māori residents' needs are being met by the service. | There are 16 residents who identify as Māori living at the facility. On admission, these residents were asked if they would like to have a comprehensive Māori care plan developed to address their needs as it relates to their culture. Interventions address how their needs will be met. Kitchen staff provide Māori kai in addition to the usual menu options, this is generally offered twice a week. Care plan interventions consider the resident's whakapapa, iwi, whānau, specific cultural information for activities of daily living and specific cultural information to be followed in the event of their death. Interviews with three Māori residents (two hospital and one rest home) and two whānau (rest home) identified that the residents' cultural needs are not only being met, but have exceeded what they expected. Cultural training is a regular and planned in-service. Further educational opportunities for staff include korero (te reo) language classes that are held with waiata (music). One of the hospital level Māori residents (interviewed) assists with teaching these classes. Many staff and residents are fluent in te reo. |
| Criterion 1.2.3.8 | CI | A quality improvement | Data collated is used to identify any areas that require improvement. Clinical indicator data |

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| <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | | <p>plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. Two QIPs reviewed in particular reflected an environment of continuous quality improvement.</p> | <p>has individual reference ranges for acceptable limits and levels of incidents and infections. Corrective action plans that have been implemented and evaluated around the reported number of residents' falls and incidents of challenging behaviours reflected significant improvements.</p> <p>Falls were identified in 2015 as an area that required improvement. A plan was developed which included identifying residents at risk of falling, implementing a falls clock to identify when falls are occurring, highlighting residents at risk through a colour coding system, providing falls prevention training for staff, ensuring adequate supervision of residents, and encouraging resident participation in the activities programme. Other initiatives included physiotherapy assessments for all residents, routine checks of all residents' specific to each resident's needs (intentional rounding), the use of sensor mats, night lights, proactive and early general practitioner (GP) and nurse practitioner (NP) involvement, and increased staff awareness of residents who are at risk of falling. Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The plan has been reviewed monthly and discussed at staff meetings. A review of the benchmarked data for the 12-month period ending in July 2017 evidenced an average falls rate that is consistently below the Ryman benchmarked target. The number of falls per 1000 bed days have either reduced or remained low and stable in all four service areas (rest home, hospital, dementia and serviced apartments).</p> <p>Clinical indicator data showed an increase in challenging behaviours for residents in the hospital and dementia units from October 2015 to April 2016. Furthermore, nursing staff wanted to feel supported and confident around completing assessments, care planning and behaviour management for residents who exhibited challenging behaviour, Care staff wanted to feel confident in initiating prevention and de-escalation techniques. An extensive action plan was developed around these areas identified for improvements. And incidents of challenging behaviours have steadily reduced, most remarkably with hospital level residents and have remained low since August 2016. Interviews with the general practitioner (GP) and nurse practitioner (NP) stated that this reduction has been noticed and is due to early interventions, early delirium screening and lab testing. The village manager and clinical manager reported that the local Alzheimer's Association recommends Kiri Te Kanawa based on their reputation for managing residents with challenging behaviours.</p> |
| <p>Criterion 1.3.13.1 Food, fluid, and nutritional needs</p> | <p>CI</p> | <p>The service has implemented a Ryman initiative called "Project Delicious" to better</p> | <p>The Ryman group identified an area for improvement around improving meal options to accommodate dislikes and meal choice including vegetarian meals, gluten free and diabetic desserts. "Project Delicious" was commenced September 2016. The four-weekly menu plan was designed in consultation with dietitians and chefs. The main meal of the day offers three</p> |

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| <p>of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p> | | <p>meet the resident's dietary preferences and dislikes by providing three options of meals at the midday and evening meal. Feedback from resident and relative interviews confirmed an increase in meal satisfaction and choice. Survey results showed an increase in resident satisfaction in meals.</p> | <p>main meal choices including two meat options and a vegetarian option. The evening meal also provides options for meat or vegetarian foods. Staff assist residents to complete their menu plan in advance. Residents may also request foods outside of the menu plan for example toasted sandwiches. The menu options accommodate resident dietary requirements/preferences and dislikes. The head chef and second chef serve the meals in the rest home and the hospital units and receive direct feedback on the meals and can monitor resident responses to the meals. The action plan included training on meal presentation and serving and table setting for all staff. The service has a "fine dining" experience in each of the care centre units monthly and family are encouraged to join the residents. Survey results for meal satisfaction in February 2016 were 3.76 (with 5 being the highest rating) and in February 2017 were 3.87. The result evidenced an increase in meal satisfaction.</p> |
| <p>Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.</p> | <p>CI</p> | <p>A power outage in Gisborne resulted in the facility providing additional support where needed. Their efforts were recognised by the local community.</p> | <p>On 12 December 2016, a topdressing plane crashed through six transmission power lines cutting power to all of Gisborne and the East Coast for 33 hours. A diesel-powered emergency generator that is installed at the village restored power to the care centre and the village centre for 33 hours in total. During this mishap, letters were emailed to residents and families to inform them of the situation. To assist independent residents, they were invited to the care centre for morning/afternoon teas, to get hot water, recharge cell phones and laptops and most importantly to socialise with others. As the power cut went into the second day, a village barbeque was held for everyone.</p> <p>There were spare beds available in the care centre. The DHB was contacted and consumers who required power (e.g., to run oxygen) were offered accommodation. Nine consumers were admitted for a period of two-five days. This was well-received by the DHB. The Gisborne district council civil defence emergency management group commended the facility on their readiness and asked to use them as a model when talking with other businesses. The facility was also recognised in the local newspaper.</p> |
| <p>Criterion 3.5.7 Results of surveillance, conclusions, and</p> | <p>CI</p> | <p>Monthly surveillance data for urinary tract infections for 2016 identified the urinary tract rates in the rest</p> | <p>The infection control coordinator identified an area for improvement around reducing urinary tract infections. An action plan was implemented that included regular discussion at handover around prevention of urinary tract infections, resident hygiene and toileting plans, increase in fluid rounds and offering of fluids in other forms other than water for example juices and lemonade, ensuring fluids are within reach. The use of disposable wipes was</p> |

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| <p>specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p> | | <p>home and hospital were above the company benchmark. The service has been successful in reducing urinary tract infections in the rest home.</p> | <p>introduced.</p> <p>The data evidenced a decrease in urinary tract infections in the rest home from February 2017 to nil in April 2017. In May 2017, the rate increased to 5.27/1000 bed days. The infection coordinator identified that the five residents were not prone to urinary tract infections. Reminders and refreshers in the prevention of urinary tract infections were immediately initiated, which saw a drop in urinary tract infections to 1.6/1000 bed days for June and July 2017.</p> <p>The service has been successful in reducing urinary tract infections below the benchmark for the rest home.</p> |
| <p>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.</p> | <p>CI</p> | <p>No restraints are currently in place. Six residents have voluntarily chosen to use an enabler (four bedrails and two lap belts) and three residents' files were reviewed. Enabler use is reviewed six-monthly, with residents consenting for the use of an enabler every six months.</p> | <p>There have been no residents who have required a restraint since November 2016. Prior to this time, only two hospital level residents were using a restraint (2016). The restraint free environment has been maintained without any increase in the number of residents' falls. Instead, falls have either reduced significantly or remained low (link to CI 1.2.3.8). Strategies implemented to remain restraint-free include mandatory staff education and training that includes staff competencies, encouraging residents at risk to not remain in their room, lounge carers, anticipating residents' needs (e.g., toileting) and intentional rounding of residents at risk.</p> |

End of the report.