

# Anthony Wilding Retirement Village Limited - Anthony Wilding Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Anthony Wilding Retirement Village Limited
<b>Premises audited:</b>	Anthony Wilding 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: 21 September 2017    End date: 22 September 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	143



# 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

Anthony Wilding provides care for up to 178 residents across three service levels (rest home, dementia and hospital-geriatric and medical). Inclusive in the 178 certified beds, is 30 certified apartments suitable to provide rest home level care. On the day of audit, there were 143 residents.

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

The village manager was employed as an assistant manager at Anthony Wilding in 2014 and was promoted to village manager July 2017. She is supported by an assistant manager, a clinical manager/RN who has been in her role for three years and a team of five unit-coordinators. The management team is supported by the Ryman management team including regional manager.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There is an improvement required around wound care documentation.

The service is commended for achieving five continuous improvement ratings around good practice, quality programme, food service, activities programme and infection surveillance 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.

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

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

The personal privacy and values of residents are respected. There is an established 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 adverse event or has a change in their health condition. Families and friends are able to visit residents at times that meet their needs.

There is an established system that is being implemented for the management of complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant to the 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 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

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is comprehensive information available. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six-monthly. The resident/family/whānau interviewed confirmed they are involved in the care plan process and review. Short-term care plans are in use for changes in health status.

The activity officers designated to provide an activities programme in each unit ensure the abilities and recreational needs of the residents is varied, interesting and involves the families and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three-monthly GP medication reviews. There is an improvement required around aspects of medication management and documentation.

Meals are prepared on-site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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 are stored safely throughout the facility. All bedrooms have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on-site at all times. Housekeeping staff maintain a clean and tidy environment.

## 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 two residents with restraint and one resident with an enabler during the 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.

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control.

## 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>	4	45	0	1	0	0	0
<b>Criteria</b>	5	95	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner'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. Twenty-seven care staff (five registered nurses (RNs), four-unit coordinators/RNs, thirteen caregivers, five activities coordinators) interviewed, confirmed their understanding of the Code and how it 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 and are included in the admission agreement. Specific consents were viewed for wound photographs and influenza vaccines. Written consents were sighted as part of the 13 resident file reviews (six hospital, four rest home including one resident in a serviced apartment and three dementia care).</p> <p>Advance directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Family members interviewed stated that the service actively involves them in decisions</p>

		that affect their relative's lives
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents 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>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. 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>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 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. Seven complaints (two rest home, four hospital, one dementia) have been received in 2017 (year to date). All complaints have been managed in a timely manner and are documented as resolved.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Six relatives (two rest home, two hospital and two dementia) and sixteen residents (five rest home with three in serviced apartments, eleven hospital) interviewed, confirmed that they have been provided with information on the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager and clinical manager reported having an open-door policy and described the process around 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.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being done. All residents' rooms have their own private ensuite.</p> <p>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' cares. Staff attend education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with local iwi and other community representative groups as requested by the resident/family.</p> <p>Family/whānau involvement in assessment and care planning and visiting is encouraged. There was one resident (dementia level) who identified as Māori at the time of the audit but was unable to be interviewed. Cultural needs were identified both in the interRAI assessment and in the resident's care plan. Whānau input was sought in the resident's care planning process.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or 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, and that staff take into account their cultural values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<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</p>

harassment, sexual, financial, or other exploitation.		boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based 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>Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the district health board which includes visits from specialists. Physiotherapists are available 20 hours per week with additional support provided by two physiotherapy assistants. There is a robust education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and annual competency assessments that monitor staff comprehension for a range of topics. Podiatry services and hairdressing services are provided. The service has established links with the local community and encourages residents to remain independent.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</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 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 in the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Twenty incident/accidents reviewed indicated that the next of kin are routinely contacted following an adverse event. Regular resident and</p>

		<p>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 were two residents living at the facility with limited English speaking abilities although staff reported that the residents were able to understand spoken English. One of their files was reviewed and the care plan included interventions to support communication. Staff and families assist with translation.</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>Anthony Wilding Retirement Village is a Ryman Healthcare facility. The service currently provides care for up to 178 residents at hospital, rest home, and dementia level care. There are also 30 serviced apartments that are approved for rest home level of care. On the day of audit there were 143 residents.</p> <p>The facility is divided into separate units. In Canterbury unit (40-bed dual purpose unit) there were 35 residents (two rest home and 33 hospital). In Wimbledon unit (40 bed dual-purpose unit, there were 35 residents (three rest home and 32 hospital). In the dementia unit there were 32 of 33 residents. In the rest home there were 34 of 35 residents. In serviced apartments, there were seven rest home level of care residents.</p> <p>Other than residents on the ARCC contract, the following contracts were in place. Three residents were on respite (two rest home and one hospital) and one resident (hospital) was on an end-of life care (medical) contract.</p> <p>The rest home and dementia unit are in a separate building (rest home ground floor and dementia unit on the first floor).</p> <p>Four residents have been admitted to the care centre under the Ryman complimentary 48-hour stay in 2017. Policy around this complimentary service is being updated at the head office (Ryman Christchurch) and is due for release in October 2017. Changes include (but not limited to) that residents using the complimentary stay in the care centre must undergo full admission procedures. This was described by the manager and clinical manager.</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 was employed as an assistant manager at Anthony Wilding in 2014 and was promoted to village manager on 31 July 2017. She is supported by an assistant to the manager, a clinical manager/RN who has been in her role for three years and a team of five unit-coordinators (two</p>

		<p>hospital/RNs, one dementia/RN, one rest home/RN and one serviced apartment/enrolled nurse [EN]).</p> <p>The village manager and clinical manager have both maintained over eight hours of professional development related to their roles in this aged care environment.</p>
<p><b>Standard 1.2.2: Service Management</b></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 to the manager are responsible during the temporary absence of the village manager, with support provided from the regional manager.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Anthony Wilding has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team (village manager, clinical manager, regional manager) and staff (27 care staff, 1 head chef, 1 head maintenance, 2 laundry, 1 health and safety representative), and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly in each wing (two hospital wings, one rest home, one dementia, one serviced apartments) and family meetings are held six-monthly. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans (QIPs) are completed where suggestions are identified with evidence sighted to support that residents and family 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 in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. 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. 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 in the hospital wings.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (activities coordinator) was interviewed. She has 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 (WSMP) (expiry 31 March 2018).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of 20 incidents and accidents 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</p>	FA	<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</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>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. Staff are also required to complete a series of comprehension surveys each year. Registered nurses are supported to maintain their professional competency. One RN has submitted her professional development recognition folder (PDRP). Eleven of twenty-five registered nurses have completed their interRAI training. There are implemented competencies specific to registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Twelve of eighteen caregivers who work in the dementia unit have completed their dementia qualification. The remaining six caregivers have been working in the unit for less than one year and are in the process of completing theirs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<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 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 two floors. Seven rest home level residents were living in serviced apartments during the audit. The serviced apartment coordinator/EN works Tuesday through Saturday. A second EN covers when she is not available (Sunday/Monday). The AM and PM shifts are staffed with two caregivers. The night shift is covered by a senior caregiver in a hospital wing (the closest to the serviced apartments). Staff communicate via mobile telecommunications.</p> <p>Two hospital wings are located on the ground floor and were occupied with seventy residents inclusive of seven rest home level residents (three in one wing and four in the other hospital wing) during the audit. The hospital wings are certified for dual-purpose. Staffing included two hospital unit coordinators/RNs, one for each wing to cover the units seven days a week. This is in addition to four staff RNs who are assigned to cover hospital level residents on the AM and PM shifts (two on each wing). Adequate numbers of caregivers are rostered on the AM and PM shifts. The night shift is</p>

		<p>staffed with two RNs (one each wing) and four caregivers (two each wing).</p> <p>The rest home is on the ground level of a second building, which is located adjacent to the main care centre. The first level of this building is the secure dementia unit. There were 34 rest home level residents and 32 dementia level residents. One unit-coordinator/RN is assigned to the rest home (Tuesday – Saturday) and one to the dementia unit (Sunday – Thursday) with a staff RN rostered on Friday and Saturday. Both areas are staffed with adequate numbers of caregivers. During the night shift, a hospital unit coordinator/RN provides oversight for the dementia unit and the rest home.</p> <p>Extra staff can be called on for increased residents' requirements. A cover pool is implemented whereby (extra) care staff are scheduled to work to cover absences. These assigned staff (sixteen caregiver shifts/week and four RN shifts/week) are scheduled to work regardless if staff are absent. Additional casual staff are available if needed.</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>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. 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</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. 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. Specific information around dementia care services is included in the information pack as applicable for dementia care admissions.</p> <p>The three files sampled from the dementia unit each had a NASC assessment determining that the</p>

		<p>resident required a secure dementia unit environment.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term and short-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of monthly blister packs is completed by two RNs and any errors fed back to the pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency. Appropriate medications were signed by two medication competent staff, one of which was a RN. The service uses an electronic medication system. Care staff and RNs interviewed could describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all four units (rest home, serviced apartments, hospital and dementia care). Medication fridges are monitored. All eye drops and creams in medication trolleys were dated on opening. There are five rest home level residents self-medicating and competencies are up-to-date.</p> <p>Twenty-two medication charts were reviewed across all units on the electronic medication system. All medications had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a</p>	CI	<p>All food and baking is prepared and cooked on-site. The qualified head chef is supported by one other chef, a weekend cook and a team of kitchen assistants. Staff have been trained in food safety and chemical safety. Project "delicious" was commenced in February 2017. Menu choices are decided by residents (or staff if the resident is not able) the day before, and offer a choice of three main dishes for the midday and two choices for evening meal including a vegetarian option. Resident dislikes are accommodated. Diabetic desserts and gluten free diets are accommodated. The seasonal menu has</p>

<p>component of service delivery.</p>		<p>been designed in consultation with the dietitian at an organisational level. Meals are delivered in hot boxes and served from bain maries in the kitchenettes.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours in all units. The clinical manager informs the head chef of residents with weight loss and dietitian input to diets.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings, survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</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 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>In the files reviewed, risk assessments had been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural, wound and restraints were completed according to need. The service has introduced the myRyman electronic resident individualised care programme. There are a number of assessments completed that assess resident needs holistically. The assessments generate interventions and narrative completed by the RNs that are transferred to the care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs are met. Thirteen resident files were reviewed (six hospital, four rest home including one resident in a serviced apartment and three dementia care). Twelve of thirteen files included up-to-date care plans that included interventions to support all current needs. The rest home resident in the serviced apartment did not have an updated care plan to reflect all current needs (link 1.3.6.1). Three hospital residents receiving end of life care reflected current assessed needs that were regularly updated. Three files were reviewed of residents in the dementia unit. All three included integrated activities of daily living that supported activities/interests across 24/7. Behaviour management/de-escalation plans were documented where assessed as needed.</p> <p>The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Residents and relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record.</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>PA Low</p>	<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 visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given [sited]). Monitoring charts are well utilised. Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Wound assessments, treatment and evaluations were in place for a sample of ten residents with wounds that were reviewed (eight hospital, two rest home). Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound documentation was incomplete for the rest home resident in the serviced apartments with two pressure injuries</p> <p>Registered nurses interviewed could describe access to wound specialist nurses if required. The GP reviews wounds regularly. New wounds were recorded in the VCare and myRyman systems.</p>

		<p>Interventions are generated in the electronic care plan following completion of assessments.</p> <p>Continence products are available and resident files included 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><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The team of activities staff (two with diversional therapy qualifications and four activities coordinators – one diversional therapist and one activities coordinator based in the dementia unit, one diversional therapist and one activities coordinator based respectively in each of the hospital units, one activities coordinator based in the rest home and one activities coordinator based in the serviced apartments) coordinate and implement the Engage activities programme across the rest home, hospital, dementia unit and serviced apartments. Rest home residents in serviced apartments can choose which programme they would prefer to attend. The programme is Monday to Friday in the rest home and serviced apartments and seven days week in the hospital and dementia care unit.</p> <p>Activities staff attend on-site and organisational in-services relevant to their roles. The designated bus driver holds a first aid certificate.</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 including Triple A exercises, themed events and celebrations, baking, sensory activities including pets coming to visit, outings and drives. A facility van is available for outings for all residents. The lounge areas have seating placed for large and smaller group activities. One-on-one activities occur as well as regular wheelchair walks out in the gardens. Daily contact is made with residents who choose not to be involved in the activity programme. The service has exceeded the required standard around the activities programme provided.</p> <p>Residents in the dementia care unit are taken for daily walks around the grounds as weather permits. Activities include music, entertainers visit weekly, pet therapy, van outings, visits to the library, triple A exercises twice a day, memory lane and group games. One-on-one sessions include hand and nail pampering and reading with residents.</p> <p>Community involvement includes entertainers, speakers, volunteers and visitors bringing in their pets weekly.</p> <p>There are opportunities for residents from all units to join together for larger celebrations, and to catch up with old friends if the resident has moved to the rest home from serviced apartments for example.</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</p>

		<p>appropriate) are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident and relative meetings and satisfaction surveys.</p> <p>In the three-dementia level myRyman files reviewed, all the information around activities to engage or distract residents over the 24-hour period were documented throughout the care plans in various sections and there was evidence of offering cups of tea during the night to settle residents in progress notes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Files reviewed identified that long-term care plans had been evaluated by registered nurses regularly and at least six-monthly. Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review.</p> <p>There is also a multidisciplinary (MDT) review completed that includes people involved in the resident's care. Records of the MDT review were evident in the resident files reviewed. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they 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>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied professionals.</p> <p>Dementia files sampled included documented evidence of input from mental health services for older people, including the nurse specialist and the geriatrician, the physiotherapist and the dietitian.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm</p>	FA	<p>There are implemented policies to guide staff in waste management - Waste Management - general waste, Waste Management - medical, and Waste Management - sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry, housekeeping and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely</p>

<p>as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The two buildings have a current building warrant of fitness that expires 1 December 2017. The service is divided into two buildings. Eighty hospital beds are divided into two units of 40 beds each (Wimbledon and Canterbury). Serviced apartments are located in the same building. The rest home and dementia care units are in another building that is easily accessible by a connecting pathway (approximately five metres). The service has a chapel, library service, hairdressers and shop for all residents to access.</p> <p>The maintenance team address any maintenance requests or call in contractors as required. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and electrical testing. An appliance asset list is maintained for facility and resident electrical equipment. Each unit has its own water supply with tempering valves on each cylinder. Hot water temperatures in resident areas are monitored monthly and stable between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.</p> <p>There is a team of grounds and garden staff that maintain the external areas. Residents are able to access the outdoor gardens and courtyards safely from all units. Seating and shade is provided.</p> <p>Staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including the following equipment; sensor mats, sensor light and bed sensor pads (dementia care unit), standing and lifting hoists, tilting shower chairs, hospital level lounge chairs, mobility aids, transferring equipment, wheel-on and chair scales, pressure relieving mattresses and cushions, electric beds and ultra-low beds</p> <p>There are quiet, low stimulus areas that provide privacy when required.</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</p>	<p>FA</p>	<p>All bedrooms in all areas have single ensuites. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are single and of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. 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>Each unit has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library area available for quiet private time or visitors. The communal areas are easily and safely accessible for residents and staff. There is adequate internal and external space to allow maximum freedom of movement while promoting safety for those that wander. The dementia care unit has an open courtyard with safe paving and walkways with entry and exit points within the secure facility. There are seating and shaded areas. There are raised gardens and vegetable gardens.</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 with the service policies and procedures. Laundry and cleaning audits are completed as per the RAP programme. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. A chemical spills kit is available. Laundry chemicals are within a closed system to the washing machines. Material safety datasheets are readily accessible.</p> <p>There are two laundry persons on duty each day. All linen and personal clothing is laundered on-site. The laundry and cleaning areas have hand-washing facilities. Cleaner's trolleys are well equipped. All chemical bottles have the correct manufacturer's labels. Residents interviewed state they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits.</p>
Standard 1.4.7: Essential,	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters.

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>Emergency management, first aid and CPR are included in the mandatory in-service programme and staff annual comprehension competency. There is a first aid trained staff member on every shift and accompanying residents on outings. 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 each area (hospital, rest home, dementia, serviced apartments) and adequate water storage on-site.</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. Residents can also choose to wear an alarm pendant (wrist or necklace). Staff use a telecommunications system to answer the phone at reception after hours and to communicate with each other if assistance is needed. Another aspect of the call system is an indicator (green light) to alert others that a staff member is in the resident's room. Call bell response times are regularly monitored and reflect acceptable response times (sighted for serviced apartments in 2017 (year-to-date)).</p> <p>Security systems are being implemented to ensure residents are safe. Staff confirmed that they conduct security checks at night.</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 heated and ventilated. There is under-floor heating throughout the facility. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control committee is combined with the health and safety committee, which meets bi-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and a six-month analysis completed by the infection control and prevention officer which is reported to the governing body.</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 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 external infection control education. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, local laboratory and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection 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. All staff complete hand hygiene audits. Infection control is an agenda item on the full facility and clinical meeting agenda. Resident education occurs as part of providing daily cares. Care plans 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</p>	CI	<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 infection prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are</p>

<p>that have been specified in the infection control programme.</p>		<p>informed through the variety of clinical meetings held at the facility. 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. A norovirus outbreak August 2016 was well managed with a comprehensive outbreak investigation log and outbreak management report.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there was one resident with a restraint and one resident using enablers. The resident file for the resident using enablers (bed rails and lap belt) reflects a restraint/enabler assessment and voluntary consent by the resident.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (hospital unit coordinator/RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. The file for the hospital level resident using restraint was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify one hourly checks were evidenced on the monitoring form for the one resident's file where restraint was in use.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in one resident file where restraint was in use. Restraint use is discussed in the RN meetings. This was confirmed in the meeting minutes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Wound assessments, plans and evaluations are completed at each dressing change and recorded in the myRyman system. Wound care documentation was being maintained for all current wounds but had not been fully completed for the rest home resident in the serviced apartments with two pressure injuries.</p> <p>MyRyman system is designed to incorporate short or long-term changes to resident needs. Overall, this has occurred in the files sampled. Twelve of thirteen files included up-to-date care plans that included interventions to support all current needs. The rest home resident in the serviced apartment did not have an updated care plan to reflect all current needs. Registered nurses and caregivers interviewed were familiar with resident's current care.</p>	<p>Rest home resident (tracer) had intermittent records for the management of the pressure injuries between July 2017 and 28 August 2017. (ii) The same resident's care plan had not been updated further to reflect increased risks and changes in condition including managing weight loss.</p>	<p>Ensure wound documentation is fully completed</p> <p>90 days</p>



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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has implemented quality improvement initiatives that reflect a rating of continuous improvement.</p>	<p>The management team identified issues relating to low staff morale and initiated a quality improvement project around developing happy staff who are proud to work at Anthony Wilding. Actions initiated have included a range of staff appreciation awards, encouraging an ‘open door’ philosophy between managers and staff, and teamwork building activities specific to each unit to build relationships between staff. Communication has also been enhanced using ‘My Ryman’, an electronic software resident database. Staff can email or text each other about meetings, upcoming education and other important communication.</p> <p>Staff turnover at the village has been decreasing steadily from 53.5% (2014) to 20.9% (current). Interviews with staff confirmed that they feel supported by management with examples provided that reflected a healthy working environment. The staff survey conducted in 2017 ranked the facility in the top four out of 29 retirement villages. And the positive morale exhibited by staff has reflected in high levels of resident satisfaction with the satisfaction survey results ranked in the</p>

			top three of Ryman facilities. This was an increase of 11 places from the previous year.
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. One QIP reviewed in particular reflected a significant reduction in residents falls at the hospital level of care.</p>	<p>Data collated is used to identify any areas that require improvement. Clinical indicator data 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 hospital level residents' falls reflected significant improvements.</p> <p>Falls in the hospital wings were identified in March 2015 as an area that required improvement (16/1000 bed nights). 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 (traffic light) 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 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 August 2017 evidenced an average (hospital level) falls rate that is consistently below the Ryman benchmarked target (10.2/1000 bed nights).</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have</p>	CI	<p>Ryman has introduced a number of systems to ensure residents nutritional needs are met. These include monitoring and acting on weight loss including prompt referrals to dietitians when the need is identified, ensuring the kitchen is aware of all current dietary requirements and kitchen staff liaising</p>	<p>In February 2016 the service commenced a programme to improve the meal service following feedback that residents were not enjoying meals.</p> <p>A plan was developed and implemented to improve the food service. Interventions including the chefs rotating through each dining room at meal times to serve the meals so they could identify what was not</p>

these needs met.		closely with residents and staff to improve meal satisfaction.	<p>being enjoyed and make changes, chefs reading and signing the communication books located in each servery where staff, residents and families can leave comments on meals, chefs talking to residents on at least a weekly basis, working with food suppliers to improve the quality of the food provided, a more robust system to ensure the kitchen are aware of the current dietary requirements of each resident, and improving the dining experience including staff etiquette, more meal choices and improved presentation of food.</p> <p>As a result of these interventions, hospital resident surveys identified improvement in meal satisfaction in the 2016 resident survey from a score of 3.52 in 2016 to 4.03 in 2017 and this improved for rest home residents from 3.83 in 2016 to 4.08 in 2017.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Ryman Anthony Wilding continues to implement the Ryman organisational 'Engage' activities programme. An activities programme, based on the Engage concepts is provided in the hospital units and dementia unit seven days per week and in the rest home and serviced apartments five days per week.</p>	<p>In February 2016 the activities staff and leadership team at Anthony Wilding identified that improvements could be made to improve resident enjoyment and participation in the activities programme.</p> <p>To achieve this, a plan was developed and implemented. Interventions included discussing the concepts and implementation of the Engage programme with the new activities team to ensure they understood the concepts, to review the Engage calendar and clarify events on the calendar, to provide education for the activities staff around the Engage programme to the activities team, to review the role of the 'lounge carer' in the hospital to ensure that they were engaging residents in activities while they were in the lounge, to review activity attendance monthly and to encourage feedback on the activities programme from residents through resident meetings and satisfaction surveys.</p> <p>Following, and as a result of the implementation of this plan, hospital resident's ratings of agreeing or strongly agreeing that they enjoy the activities programme increased from a rating of 3.60 in 2016 to 4.14 in February 2017. Rest home resident results increased from 3.83 in February 2016 to 4.0 in February 2017.</p>

<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Anthony Wilding implements a comprehensive infection control programme that links to the Ryman quality and risk management programme. Infections are documented on a monthly summary report that includes clinical summary, interventions and evaluations. Environmental monitoring is also determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets. The QIP process is seen to have been well embedded into day-to-day operations at Anthony Wilding and include clinically focused improvements. A QIP was reviewed for two needle stick injuries March 2017.</p>	<p>The service has undertaken a number of initiatives as a result of infection surveillance data to reduce infection numbers. IC statistics are discussed at all meetings and corrective actions are implemented when infections increase. Monthly summaries of infections include actions required. A six-monthly trend analysis and clinical indicator report also identifies opportunities for improvement. An example includes where strategies have been implemented at Anthony Wilding to reduce infections and evaluations show that the service benchmarking identified Anthony Wilding has kept UTIs below the company threshold March – May 2017 and respiratory infections below the threshold in April, May.</p>
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End of the report.