# Shona McFarlane Retirement Village Limited - Shona McFarlane 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Shona McFarlane Retirement Village Limited

**Premises audited:** Shona McFarlane Retirement Village

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

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

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 77

# 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** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Shona McFarlane facility is part of the Ryman group providing care for up to 79 residents in the care centre and up to 20 residents at rest home level in serviced apartments. On the day of audit, there were 77 residents in the care centre and no residents in the serviced apartments.

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 has been with the Ryman company 19 years and in the current role for the last five years. She is supported by an assistant manager and clinical manager. 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 were no areas for improvement identified at this audit.

The service is commended for achieving continuous improvement ratings around good practice, quality initiatives, food service and activities 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 manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. Shona McFarlane has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Shona McFarlane provides clinical indicator data for the two services being provided (hospital and rest home). There are human resources policies including recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |

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 diversional therapists provide an activity programme in each wing that ensures the abilities and recreational needs of the residents is varied, interesting and involves the families and community.

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.

Meals are prepared on-site. The menu is designed by a dietitian at organisational level. Individual and special dietary needs are catered for.

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. |

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. |

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 using restraints and one resident with two enablers 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. |  | Standards applicable to this service fully attained. |

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)** |
| **Standards** | 2 | 43 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 89 | 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)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | 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. Twelve care staff (two registered nurses (RNs), two unit coordinators and eight caregivers) 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.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | 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. Nine resident files reviewed (five rest home including one resident for respite care and four hospital level of care residents) included written consents. 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 as required. 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 that affect their relative’s lives.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | 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.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | 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. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are available 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. 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. Five complaints have been received in 2017 (year-to-date). All complaints have been managed in a timely manner and are documented as resolved. The regional manager reported that all complainants are contacted by Ryman Christchurch to ensure that their complaint is resolved. If the complaint is not resolved, the regional manager becomes involved.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | 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 (four rest home and two hospital) and six residents (three rest home and three 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.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents’ privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being done. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. 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 in November 2017. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with local iwi and other community representative groups (ie, Koranui Marae) as requested by the resident/family. Family/whānau involvement in assessment and care planning and visiting is encouraged. There was one resident who identified as Māori at the time of the audit. 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.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers 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, and that staff take into account their cultural values.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | CI | 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. 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 teamRyman 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 facility level. Management at facility level are then able to implement changes to practice, based on the evidence provided. Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the district health board which includes visits from specialists. There is close liaison with the hospice team who provide support for end of life residents. The service has exceeded the standard around end of life care. A physiotherapist is available 12 hours per week with additional 15 hours support provided by a physiotherapy assistant. 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 are provided seven hours a fortnight. The service has established links with the local community and encourages residents to remain independent.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a 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. Regular contact is maintained with family including if an incident or care/health issues arise. 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. Twelve incident/accidents reviewed for November 2017 indicated that the next of kin are routinely contacted following an adverse event. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed for residents who are unable to speak or understand English.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Shona McFarlane Retirement Village is a Ryman Healthcare facility. The service provides care for up to 79 residents in the care centre at hospital and rest home level of care. All 79 beds are dual-purpose. There are also 20 serviced apartments certified to provide rest home level of care. There were no rest home residents in the serviced apartments at the time of the audit. On the day of audit, there were 77 residents in total, 29 hospital level residents including one hospital level care resident on respite care and 48 rest home residents, including three rest home residents on respite care. All other long-term residents were under the aged related residential care (ARRC) agreement. Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Quality objectives for the 2016 year have been reviewed and 2017 objectives in place. There is a health and safety, and risk management programme being implemented at Shona McFarlane. The village manager (non-clinical) has been in this role eight years and has had a total of 19 years with Ryman. The village manager is supported by a full-time experienced clinical manager who has been in the position for one and a half years. She is supported by a hospital unit coordinator, rest home unit coordinator and serviced apartments unit coordinator. Management are supported by a regional manager and operations & clinical manager, who was present during the audit.The village manager and clinical manager have attended a two-day Ryman conference and leadership programme in the last year.  |
| Standard 1.2.2: Service Management 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.  | FA | The clinical manager is responsible during the temporary absence of the village manager, with support provided from the assistant manager and regional manager. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Shona McFarlane has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing 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. 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. The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The 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 and maintained a reduction in challenging behaviour incidents. Health and safety policies are implemented and monitored. The health and safety officer (caregiver) was interviewed. She has completed external health and safety training. Health and safety meetings are conducted 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 management and staff meetings. Ryman has achieved tertiary level ACC workplace safety management practice (WSMP), expiry 31 March 2018.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of twelve incident/accidents forms identified that all are fully completed and include follow-up by a RN. 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. The village manager was able to identify situations that would be reported to statutory authorities. A section 31 report was sighted for a stage three pressure injury. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (one clinical manager, two-unit coordinators, two RNs, four caregivers, one activities coordinator and one cook) included a signed contract, job description relevant to the staff members role, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff. A register of RN practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan for 2017. 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. Five of ten RNs have completed their interRAI training. There are implemented competencies specific to RNs and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ryman policy supports the requirements of skill mix, staffing ratios and rostering. There is a RN and first aid trained member of staff on every shift. Caregiver’s interviewed stated that management are supportive and approachable. Staff interviewed advised that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm that there are sufficient staff on duty. The village manager and clinical manager both work 40 hours per week. There are 20 serviced apartments certified to provide rest home level of care. There were no rest home level residents living in serviced apartments at the time of the audit. The facility has two units, the Sunflower rest home and the Tulip hospital unit. There is a full-time unit coordinator at the rest home and hospital units.Staffing at Shona McFarlane is as follows; In the Sunflower rest home unit there are 39 residents in total (29 rest home and 10 hospital residents) on the morning shift: there is one RN and four caregivers, afternoon shift: there are four caregivers, night shift there are two caregivers, the RNs in the hospital oversee the rest home unit in the afternoon and night shifts. In the Tulip hospital unit there are 38 residents in total (19 hospital and 19 rest home residents). On the morning shift: there are two RNs and eight caregivers, afternoon shift there are two RNs and six caregivers, night shift there is one RN and three caregivers. There is also an additional fluid nurse on duty in the morning shift and one lounge carer on duty in the afternoon shift. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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 of the public. Residents’ files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrate service integration. |
| 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. | FA | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. 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. The admission agreement reviewed aligns with the services contracts for long-term and short-term care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | 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. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. 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. Education around safe medication administration has been provided. Appropriate medications were signed by two medication competent staff, one of which was a RN. The service uses an electronic medication system. Medications were stored safely in all units. Medication fridges are monitored weekly. All eye drops in medication trolleys were dated on opening. There were no residents self-medicating on the day of audit. Eighteen medication charts were reviewed (eight hospital and ten rest home). Sixteen medication charts were on the electronic medication system and two were paper-based for respite care residents. All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP (for permanent residents). 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. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All food and baking is prepared and cooked on-site. The qualified head chef is supported by one other chef on duty daily and a team of kitchen assistants. Staff have been trained in food safety and chemical safety. Project “delicious” has been in place almost one year. 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 meal and two choices for the evening meal, including a vegetarian option. Resident dislikes are accommodated. Diabetic desserts and gluten free diets are accommodated. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Meals are delivered in hot boxes and served from bain maries in the hospital wing and serviced apartment dining room. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Alternative foods are available on the menu or offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are available after hours. Freezer and chiller temperatures and end cooked temperatures are taken and recorded 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. Residents can provide feedback on the meals through resident meetings, food communication books in each servery, resident survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided. |
| Standard 1.3.2: Declining Referral/Entry To Services 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.  | FA | 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. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | 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 physiotherapy assessments 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. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | 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. The long-term care plans of permanent residents and one respite nursing care plan included interventions to support all current needs. 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 identity 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. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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, (eg, 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. Wound assessments, treatment and evaluations were in place for a sample of eight residents with wounds that were reviewed (six 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 care documentation was complete, including photos for the six hospital residents with pressure injuries (three facility acquired and three hospital acquired including one stage three pressure injury).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. Interventions are generated in the electronic care plan following completion of assessments. 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. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | The service employs two qualified diversional therapists for 32.5 hours each with one based in the rest home wing and the other in the hospital wing. A lounge carer in the hospital wing from 6.00 pm daily spends one-on-one time with residents as required. There is a weekend activity coordinator who coordinates activities across both the rest home and hospital wings. Activities staff attend on-site and DT workshops relevant to their roles. The DTs and designated bus driver hold a current first aid certificate.The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including but not limited to; Triple A exercises, board games, news and views, poets corner, memory lane, baking, men’s group, sensory activities including pet therapy, themed events and celebrations. Rest home residents in serviced apartments can attend either the serviced apartment or rest home/hospital programmes. Some activities are integrated for all residents including entertainment. One-on-one activities occur as well as regular wheelchair walks around the village and the gardens. Daily contact is made with residents who choose not to be involved in the activity programme. Community involvement includes entertainers, speakers, volunteers and regular church services. There are regular van outings and drives to places of interest and community events. A mobility taxi is hired for hospital level resident outings. The service has exceeded the required standard around accessible gardening activities for hospital level residents. 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 can feedback on the programme through the resident and relative meetings and satisfaction surveys. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | 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. There is also a multidisciplinary (MDT) review completed that includes the RN, caregivers, DT, physiotherapist, resident, relative and any other health professionals 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. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | 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. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | 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 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 throughout the facility. Safety datasheets are available.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The buildings have a current building warrant of fitness that expires 8 March 2018. The service has serviced apartments and the care centre on the ground floor and independent apartments on the first floor. The service has a library service, hairdressers and shop for all residents to access. The maintenance manager has been in the role three months and has a background in engineering. A maintenance and repairs register is maintained (sighted) for all areas. 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. There are essential contractors available 24/7. The maintenance manager is available on-call for urgent facility matters. Hot water temperatures in resident areas are monitored three monthly as part of the environmental audit and are stable below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the rest home and hospital wings for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. There is a team of ground and garden staff that maintain the external areas. Residents are able to access the outdoor gardens and courtyards safely from both wings. Seating and shade is provided. 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, standing and lifting hoists, hospital level lounge chairs, mobility aids, transferring equipment, wheel-on and chair scales, pressure relieving mattresses and cushions, electric beds and ultra-low beds.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | All bedrooms are single with full toilet/shower 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.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All residents’ rooms are of an appropriate size in both wings 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 as viewed on the day of audit.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are separate dining rooms in the rest home wing and hospital wing. The lounges are spacious, where most activities take place. There is an additional lounge that is available for quiet activities or family visits. The communal areas including the grounds and internal courtyard are easily accessible.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | 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 Team Ryman 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. All linen and personal clothing is laundered on-site. The laundry operates from 8.00 am to 7.00 pm daily. 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. There are designated laundry persons on duty each day. Cleaner’s trolleys (sighted) were well equipped. All chemical bottles have the correct manufacturer’s labels. Cleaners trolleys are kept in locked cupboards when not in use. 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.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Staff attended emergency and disaster management training in October 2017. Emergency management, first aid and CPR are included in the mandatory in-service training programme and staff annual comprehension competency. There is a first aid trained staff member on every shift and accompanying residents on outings. Shona McFarlane has an approved fire evacuation plan and fire drills have occurred six monthly. There are three civil defence kits in the facility and adequate water storage on-site. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (four BBQs) and a generator available in the event of a power failure. Emergency lighting is in place for four hours. Call bells are in residents’ rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. The service utilises security cameras and an intercom system.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. There is ceiling heating throughout the facility. New air conditioning units have recently been installed. All rooms have external windows with plenty of natural sunlight.  |
| Standard 3.1: Infection control managementThere 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.  | FA | The infection prevention and control programme are appropriate for the size and complexity of the service. The infection prevention and control committee are combined with the health and safety committee, which meets bi-monthly. The full 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 is completed by the infection control and prevention officer (clinical manager), which is reported to the governing body. 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. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | 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 education via teleconference May 2017. She attends a six-monthly teleconference with other Ryman infection control and prevention officers. The facility also has access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation. |
| Standard 3.3: Policies and proceduresDocumented 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. | FA | 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. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 on-line 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 informed through the variety of clinical meetings held at the facility and are displayed on the staff noticeboard. The infection prevention and control programme links with the quality programme including internal audits. 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. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | 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 using restraints and one resident using two enablers. The resident file for the resident using enablers (bed rail and lap belt) reflects a restraint/enabler assessment and voluntary consent by the resident. Staff training has been provided around restraint minimisation and enablers, falls prevention, and the management of challenging behaviours. |

# 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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| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | In September 2016 the service identified an improvement was required around end of life (EOL) care following two relative concerns on communication and pain relief. The service has achieved its aim to provide a holistic approach to EOL including consultation with families, hospice and specialists. Positive feedback on EOL care has increased the services profile in the community and hospice for providing best palliative care.  | To achieve this, a plan was developed and implemented that identified areas of improvement around consultation and communication and timely pain relief to ensure holistic care enhanced the resident and family end of life experience. Interventions included; developing a stronger partnership with hospice, all RNs, care assistants and DTs attended palliative care education sessions, a palliative care kit was set up including personalised linen, bedding, candles, CD player and music which facilitates a calm peaceful environment, family/resident meetings with the hospice team, GP and clinical staff as soon as the resident was identified for EOL care and RNs involved in all aspects of care and communication as soon as resident became palliative. There has been improved pro-active prescribing for optimal pain management. The GP interviewed confirmed palliative care including pain relief is very well done at Shona McFarlane. The service has achieved its goal to provide best palliative care. Evidence has been gathered by way of feedback from bereaved families (verbal and written), the folder of cards and letters of thanks from families (sighted), GP interview and staff interviews. Correspondence from hospice confirms the working relationship between hospice and Shona McFarlane has been strengthened. Hospice has a high level of confidence in the palliative/EOL care that is provided by staff at Shona McFarlane. Records show there have been seven referrals (many complex cares) from hospice over the last three months to Shona McFarlane.  |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | CI | 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 challenging behaviour episodes. | 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 residents challenging behaviour episodes reflected significant improvements. Challenging behaviour episodes were identified in August 2016 as an area that required improvement (1.0 per 1000 bed nights). A plan was developed, which included identifying residents at risk of challenging behaviour episodes, implementation of intentional rounding to anticipate resident’s needs. Challenging behaviour education for staff occurred in September 2016 and April 2017. Challenging behaviour analysis was reviewed monthly and discussed at clinical/RN and staff meetings. A review of the benchmarked data for the 12-month period ending in August 2017 evidenced an average rate that is consistently below the Ryman benchmarked target (0.3/1000 bed nights). Shona McFarlane had the lowest challenging behaviour rate in the Ryman group for the period from 1 September 2016 to 31 August 2017. Shona McFarlane also has had zero episodes of challenging behaviour between 1 August 2017 and 12 December 2017. |
| Criterion 1.3.13.2Consumers who have additional or modified nutritional requirements or special diets have these needs met. | CI | 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 closely with residents and staff to improve meal satisfaction. | In February 2016 the service commenced a programme to improve the meal service following feedback that residents were not enjoying meals.A plan was developed and implemented to improve the food service. Interventions including: the chefs rotating through each dining room at mealtimes to serve the meals, so they could identify what was not 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 raw quality of the food provided;, sourcing a supplier for high food value and flavoured pureed foods, and improving the dining experience including staff etiquette for residents. Project delicious was implemented with four-week rotating menus (summer and winter) providing more meal choices which also caters for a vegetarian and gluten free option. A second chef on duty has been employed to ensure the aim of project delicious options can be met. The midday meal provides three main options and two options of desserts. Dinner provides a choice of two options. As a result of these interventions, hospital resident surveys identified the greatest improvement in meal satisfaction in the 2017 resident survey from a score of 3.13 in 2016 to 4.00 in 2017 and this improved for rest home residents from 3.67 in 2016 to 3.81 in 2017.  |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | Ryman Shona McFarlane continues to implement the Ryman organisational ‘Engage’ activities programme. There is the flexibility to add activities identified by residents as interests or recreational preferences. The service has been successful in introducing a gardening activity designed for hospital level residents.  | In February 2017 the activities staff and residents at Shona McFarlane identified that gardening activities could be made more enjoyable with greater participation for hospital level residents if the gardens and garden pots were more accessible. To achieve this, a plan was developed and implemented that involved the residents and community. Residents, family and staff initiated fundraising events for the purchase of timber to build specifically designed raised gardens that are mobile and built to fit wheelchairs and chairs to enable hospital level residents to participate in the planting and gardening activity. A qualified builder and several sponsors volunteered time and materials. The garden club now has 15 members who proudly wear their garden club T-shirts and meet regularly to discuss the planting calendar. The garden beds (viewed) are located in the Tulip (hospital) wing courtyard and were fully planted with produce including tomatoes and many herbs. Residents enjoy the benefits of a meaningful activity, fresh air and exposure to Vitamin D. The garden produce is donated to the cooking club with all residents being able to enjoy the baking and shared salads. The garden club now includes rest home residents and are of interest to visitors on-site and the village people. There is documented evidence of resident enjoyment and positive relative feedback in resident and relative meeting minutes (sighted). Verbal feedback was received on the day of audit from resident and relative interviews.  |

End of the report.