

# Julia Wallace Retirement Village Limited - Julia Wallace Retirement Village

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Julia Wallace Retirement Village Limited
<b>Premises audited:</b>	Julia Wallace 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: 24 January 2018      End date: 25 January 2018
<b>Proposed changes to current services (if any):</b>	

**Total beds occupied across all premises included in the audit on the first day of the audit: 89**

# 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

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

## General overview of the audit

Ryman Julia Wallace provides rest home, hospital and dementia level of care for up to 104 residents. There were 89 residents at the time of the audit.

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

The village manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There are three areas of continuous improvement awarded around good practice, corrective action plans, and food and nutrition services.

## 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 incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

Informed consent procedures and advance directives are discussed with residents on admission. 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 on-site seven days a week with additional on call cover 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.		Standards applicable to this service fully attained.
--	--	--

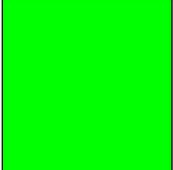
There is a comprehensive information package for residents/relatives on admission to the service. InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme which is varied and interesting. The engage programme meets the abilities and recreational needs of the group of residents including a men's group.

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

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food that is provided.

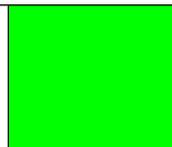
## Safe and appropriate environment

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 were stored safely throughout the facility. All bedrooms are single occupancy with full ensuites. There are adequate numbers of communal toilets. There was sufficient space to allow the safe movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

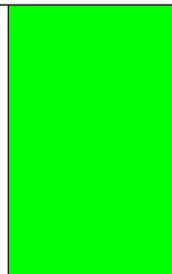


Standards applicable to this service fully attained.

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 five residents with restraint and three residents with 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 prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. The service has had two outbreaks since the last audit that were well-managed.

## 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>	1	49	0	0	0	0	0
<b>Criteria</b>	3	98	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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. Two managers (one village manager, one clinical manager) and twenty-one care staff interviewed (two registered nurses (RNs), four unit coordinators (three RNs, one enrolled nurse (EN), ten caregivers (six am shift and four pm shift with two who work in the dementia unit, three hospital, two serviced apartments and three in the rest home), three diversional therapists and two activities coordinators) were able to describe how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents form part of the admission agreement as sighted for 10 resident’s files reviewed (four hospital, three rest home including one resident in the serviced apartments and three dementia care files). There are specific written consents for procedures including wound photographs, influenza vaccines and indwelling catheters.</p> <p>Advanced directives are signed for separately. Copies of EPOA are kept on the residents file where required. The EPOAs had been activated in the three dementia care resident files reviewed. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussions with family members</p>

<p>they need to make informed choices and give informed consent.</p>		<p>confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>All resident files reviewed have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in visible locations around the facility. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. They reported that they would feel comfortable addressing a concern with the village manager and/or clinical manager. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Eight complaints received in 2017 (one serviced apartments, one rest home, four hospital, one special care unit (dementia) have been managed in a timely manner and are documented as resolved. No complaints have been lodged with HDC or the DHB since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code with residents and families during the admission process. Nine relatives (three rest home, four hospital and two dementia) and ten residents (six rest home with one in a serviced apartment and four hospital) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The managers reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<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</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. Family/whānau involvement in assessment and care planning and visiting is encouraged. Links are established with local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in a comprehensive manner. There were two residents who identified as Māori at the time of the audit but were unable to be interviewed. Residents/whānau are provided with a choice whether or not they would like to have a Māori care plan developed. This was evidenced for one Māori resident in the special care (dementia) unit.</p>

beliefs.		
<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 multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents and relatives interviewed confirmed that staff take into account their cultural values where indicated.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</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 boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>All Ryman facilities have an electronic 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</p>

		<p>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. A physiotherapist is available 12 hours per week with additional support provided by a physiotherapy assistant. There is a robust education and training programme for staff that includes in-service training and annual competency assessments that monitor staff comprehension for a range of topics. RNs attend a journal club meeting every two months. 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 on the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Fifteen incident/accident forms and corresponding residents' files were reviewed and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.</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>	FA	<p>Julia Wallace is a Ryman Healthcare retirement village located in Palmerston North. They are certified to provide rest home, hospital and dementia levels of care in their care centre for up to 84 residents. There are also 20 serviced apartments that are certified to provide rest home level care. Sixty-three beds in the care centre are certified as dual purpose beds and twenty-one beds are available in the special care unit for dementia level of care.</p> <p>Occupancy in the care centre was 29 rest home, 32 hospital and 21 dementia level residents. There were seven rest home level residents in the serviced apartments. The hospital level of care is certified for geriatric and medical. All residents at the facility were on the ARC contract.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Annual objectives are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress</p>

		<p>towards meeting these objectives. Staff are kept informed of progress in the full facility meetings.</p> <p>The village manager has been in her role at this facility since May 2013 and prior to this she was a regional manager in aged care for three years. She trained as a medical technologist. The village manager is supported by a regional manager, an assistant manager and a clinical manager/RN. She has attended a minimum of eight hours of professional development per year relating to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager and assistant to the manager are responsible during the temporary absence of the village manager, with added support provided by the regional manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Ryman Julia Wallace 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 twenty-five staff (twenty-one care staff, one head chef, one acting maintenance, one cleaner, one laundry), and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly. Minutes are maintained. Annual resident and relative surveys are completed with the last survey completed in February 2017. Results are benchmarked against all Ryman facilities.</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.</p>

		<p>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 identify 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 staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Health and safety policies are implemented and monitored. Two health and safety officers were interviewed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice (expiry 31 March 2018).</p> <p>The service has achieved a continuous improvement in relation to the results achieved from corrective action plans that were implemented to reduce the number of residents' falls, and the frequency of challenging behaviour incidents.</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>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of 15 incidents and accidents for 2017 identified that all forms were 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 with examples provided. There have been no instances that have required a report to be completed since their last audit.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Twelve staff files reviewed (one chef, two unit coordinators, two staff RNs, one diversional</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>therapist and six caregivers) included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in, and completed induction checklists. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Journal club meetings are provided two-monthly. Ten of fourteen registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Fifteen of nineteen caregivers who work in the dementia unit have completed their dementia qualification. The remaining four caregivers have been employed for less than one year in the dementia unit and are in the process of completing their qualification.</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 facility covers two floors with an elevator and stairs for access. The clinical manager is an experienced registered nurse with a current practising certificate who works full time Tuesday-Saturday. She is supported by four unit coordinators (three RNs (rest home, dementia, hospital) and one enrolled nurse (serviced apartments) who stagger a seven day a week schedule.</p> <p>There are twenty serviced apartments certified to provide rest home level of care that span two floors with seven rest home level residents during the audit. The serviced apartment unit coordinator (EN) or a senior caregiver cover seven days a week and are supported by two caregivers on the AM shift (one long and one short shift) and two caregivers on the PM shift (short shift only). The rest home caregivers cover the serviced apartments after 9 pm and through the night shift. Staff communicate via mobile telecommunications.</p> <p>The care facility is located on the ground floor. Staffing includes a hospital unit coordinator/RN (Sun - Thurs) and a rest home unit coordinator/RN (Tues - Sat). This is in addition to two staff RNs who are assigned to cover hospital level residents on the AM and PM shifts. The night shift is staffed with one RN and six caregivers.</p> <p>The first level includes the secure dementia unit (21 beds, currently 21 residents). The dementia unit is staffed with a unit coordinator (RN) from Tues – Sat and an RN on Sunday and Monday. There are two caregivers who work</p>

		<p>the AM shift (long shifts), and three caregivers who cover the PM shift (two long and one short shift). Two caregivers cover the night shift.</p> <p>A cover pool has been implemented whereby (extra) care staff are scheduled to work Friday – Monday to cover absences. 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. The welcome pack also includes information specific to dementia level of care.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term care. Clear processes exist that support older people and their families to understand what the payments are for and that they do not have to accept premium payments, there are choices available to access non-premium charging DHB beds. This could be described by the facility manager and reflected in interviews with relatives.</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>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Signatures on the back of the medication packs evidenced medication reconciliation by two RNs. Any errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided by the pharmacist June 2017. Medications were stored safely in all units. Medication fridges are monitored daily. Three self-medicating residents (one rest home and one hospital) had been assessed and reviewed by the GP and RN as competent to self-administer.</p> <p>Twenty-one charts (eight hospital, six rest home and six dementia care) medication charts were reviewed on the electronic medication system. Medication charts had photo identification, allergy status and had been reviewed three-monthly by the GP. All medication charts reviewed have 'as needed' medications prescribed with an indication for use. 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 component of service</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by a head cook, cook's assistant and team of kitchen assistants. The head chef is a food services assessor. Staff have been trained in food safety. Project "delicious" has been in place almost one year. Menu choices are ordered by residents (or staff if the resident is not able) the week before.</p> <p>The four-weekly seasonal menu offers several meal choices including a vegetarian option. The menu choices accommodate resident dislikes and gluten free diets. 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 each unit. The chef rotates around the dining rooms serving the main meal.</p> <p>Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours in the dementia</p>

<p>delivery.</p>		<p>care unit.</p> <p>Freezer and chiller temperatures, end cooked and serving temperatures are taken and recorded daily. The chilled goods temperature is checked on delivery. All foods were date labelled. Decanted dry goods had expiry dates. 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, 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.</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 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>The facility has embedded the interRAI assessments within its clinical practice. Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that were triggered reflected appropriate interventions in the care plans reviewed. Additional assessments such as behavioural, wound and restraints were completed according to need. In the resident files reviewed the outcomes of all assessments, needs and supports required were reflected in the care plans.</p>
<p>Standard 1.3.5: Planning Consumers' service</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans were resident centred and support needs and interventions were documented in detail to reflect the outcomes of clinical assessments. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect changes in health status and were reviewed</p>

<p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>on a regular basis. Residents and family stated they were involved in the care planning and review process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>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 are updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place for 17 residents with wounds (skin tears abrasions and 2 chronic ulcers). There were no pressure injuries. Adequate dressing supplies were sighted in the treatment rooms. The wound care champion (hospital coordinator) for the service provides advice and support to RNs and reviews wounds weekly. She has access to the DHB wound nurse as required and links into the wound care society meetings.</p> <p>Contenance products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RN's interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight; blood pressure and pulse; neurological observations post unwitnessed falls or identified head injuries; food and fluid charts; restraint monitoring; pain monitoring; blood sugar levels; and behaviour charts. Progress notes document changes in health and significant events.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of three diversional therapists (DT) and two activities coordinators (in DT training) to deliver the engage programme across the rest home, hospital, dementia care unit and serviced apartments. Activity coordinators attend on-site and organisational in-service relevant to their roles. All have current first aid certificates.</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. Rest home residents in the serviced apartments attend either the serviced apartment or rest home programme. The engage programme is seven days a week in the hospital and dementia care units and Monday to Friday in the rest home and serviced apartments. Lounge carers on the afternoon in the hospital support the DT with activities. There are plentiful resources available. Residents receive programmes in their rooms as appropriate. Daily contact is made with residents who choose not to be involved in the activity programme. Twice a week there are two DTs on in the afternoons where residents have a choice of activities to attend and one-on-one time is spent with residents unable to participate in group activities. Triple A exercises occurs daily in each unit to meet the physical and cognitive abilities of the residents. There are regular</p>

		<p>supervised walks outside. The physio aide takes residents in the dementia care unit for outdoor walks either in a small group or individually (as appropriate). This was confirmed in interview with staff and relatives. Activities are integrated for all residents at least weekly. There are many other activities that are open to all residents including: entertainment; mass picnics; village spelling bee; quizzes; children's party (off-site); and men's group. There are regular van outings for shopping, visits to cafes and places of interest and more recently plane spotting has been enjoyed by residents. Residents are encouraged to maintain links with the community such as RSA. There are many community visitors including entertainers, guest speakers, pet therapy and book club.</p> <p>Weekly interdenominational church services are held on-site in the chapel and monthly in the dementia care unit.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Seven of ten care plans had been evaluated six-monthly by registered nurses. Three residents (one hospital and two dementia care) had not been at the service six months. Written evaluations describe the resident's progress against the residents identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals such as the physio involved in the care of the resident. 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</p>	<p>FA</p>	<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 services.</p>

consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets and product use information was readily available. Staff have attended chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 9 December 2018. The facility has two levels with the care centre (rest home and hospital) on the ground level and dementia care unit and serviced apartments on the first floor. There is lift and stair access between the levels.</p> <p>The maintenance person ensures daily maintenance requests are addressed. He maintains a 12-monthly planned maintenance schedule which has been signed off monthly as completed (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor.</p> <p>Hot water temperatures in resident areas are monitored as part of the three-monthly environmental audit. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens, atrium and courtyards safely. Seating and shade is provided.</p> <p>The dementia care unit has an internal walking area and residents have access to a safe outdoor deck with seating, shade and raised gardens. An open conservatory area has been built off the lounge. The conservatory provides another area for outdoor activities and barbeques.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All bedrooms are single occupancy and have full ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<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>	<p>FA</p>	<p>All resident's rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids and hoists. Residents are encouraged to personalise their bedrooms as viewed during the audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age</p>	<p>FA</p>	<p>The rest home unit and hospital unit each have a separate lounge area and dining room. There are seating alcoves, a library room and a family room within the care centre. Both units have an internal courtyard. The large main lounges have seating placed to allow for individual or group activities. There is a hairdresser, shop and chapel/reflection room available to all residents. The dementia unit has a spacious combined dining room and lounge area.</p>

appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The chemical provider monitors the effectiveness of chemicals and provides training. An air conditioning unit has been installed since the previous audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory education programme. There is a minimum of one first aid trained staff member on every shift. The village has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities are in place. There is a civil defence kit in the facility and adequate water storage on-site. A diesel-powered generator is available in the event of a power outage.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. The call bell system is linked to staff pagers and to the call bell panels in the rest home. Residents can choose to wear an alarm pendant. 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</p>	FA	<p>General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight. Internal ground floor rooms open out onto the atrium.</p>

light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<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 clinical and 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 and reported to the governing body. The clinical manager is the infection prevention and control coordinator at the facility and has a job description that outlines responsibilities.</p> <p>Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine. There are adequate hand sanitizers 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 coordinator has completed induction into the role August 2017 and has since completed the MOH online infection control course October 2017. The infection control coordinator also attends managers ARCC forums at the DHB. The facility also has access to an infection prevention and control nurse specialist from the DHB and expertise within the organisation, public health, GPs, local laboratory and external infection control consultant. There is also support from other clinical managers within Ryman.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies</p>	FA	<p>There were comprehensive infection prevention and control policies that were 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 consultant. The infection prevention and control</p>

<p>and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>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>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions. All staff complete annual hand hygiene competencies and infection control comprehension surveys. 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 that have been specified in the infection control</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control coordinator completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p>

programme.		There was a confirmed norovirus outbreak July 2017 and an influenza outbreak in September 2016. Public Health was notified and documentation demonstrates both outbreaks were well-managed.
Standard 2.1.1: Restraint minimisation  Services 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 five residents with restraint and three using enablers.  One resident file was reviewed for the use an enabler and reflected an assessment, voluntary consent process (gained from the resident) and regular (six-monthly) reviews.  Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes  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.	FA	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.
Standard 2.2.2: Assessment  Services shall ensure rigorous assessment	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RNs in partnership with the GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. Two files were selected for review (one bed

of consumers is undertaken, where indicated, in relation to use of restraint.		rail and one chair brief). The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	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 was documented to verify checks were evidenced on the monitoring form for the two residents' files 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>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted six-monthly. Restraint use is discussed in the RN meetings, confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	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.

## Specific results for criterion where corrective actions are required

---

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

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

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

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

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

---

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

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

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

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 environment at Ryman Julia Wallace encourages good practice with a particular example provided around support that is provided to relatives in the special care (dementia) unit.</p>	<p>The unit coordinator in the special care (dementia) unit identified spouses who were in need of additional support and felt that there was a need to improve communication with relatives and to build a rapport with spouses. An action plan was developed to address the needs of families that included the creation of a monthly support/coffee group (initiated April 2017), build rapport with spouses by arranging informal meetings and encouraging relatives to be comfortable expressing their concerns in a safe manner, and provided additional education for staff on communication and dementia (three in-services were provided in 2017 around dementia therapies, sensory loss and communication). Feedback from relatives in meetings, in satisfaction surveys and in family interviews during the audit confirmed the positive benefits of this initiative. Several new spouses have joined the support group while spouses of residents who have passed away continue to attend the support group. Spouses know each other by name and support each other during their visits and in their time away from the unit. The relative satisfaction survey evidenced an increase in satisfaction with communication (2016 – 4.00 and 2017 – 4.14 out of a possible score of 5). It is also felt that the relatives being more relaxed in this environment have resulted in a reduction in the number of behaviours that challenge (link to CI 1.2.3.8).</p>

<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>	<p>CI</p>	<p>A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. Two QIP's reviewed in particular reflect an environment of continuous quality improvement.</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 residents' fall and incidents of challenging behaviours reflect significant improvements.</p> <p>Falls were identified in 2017 as an area that required improvement for both rest home and hospital level residents with the number of falls per 1000 bed nights exceeding the Ryman target. A plan was developed which included identifying residents at risk of falling, 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 regards to preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly and is regularly discussed at staff meetings. A review of the benchmarked data for the 12-month period ending in Dec 2017 evidenced a falls rate that has fallen below the Ryman benchmarked target for both rest home and hospital level residents. For rest home level residents, the highest rate was 8.6/1000 bed nights in July 2017 with the lowest rate 1.4 bed nights in October 2017. For hospital level residents, the lowest falls rate was achieved in October 2017 (3.9/1000 bed nights).</p> <p>Clinical indicator data for January 2017 reflected a significant number of challenging behaviour incidents for hospital and dementia level residents with 3.1 events per month per 1000 bed nights for hospital level residents and 7.9 events per month per 1000 bed nights for dementia level residents. A corrective action plan was developed, which included staff education, liaising with activities staff around engaging residents, open communication with families and GP reviews of medication where relevant. Incidents of challenging behaviours have steadily reduced for residents in both the hospital and dementia units. There were .9 events/month/1000 bed nights for hospital level residents for Nov 2017 and 3.2 events/month/1000 bed nights for dementia level residents. Although this increased slightly in December due to the holidays, numbers remained lower than for the first quarter of 2017.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers</p>	<p>CI</p>	<p>Ryman has introduced a number of systems to ensure residents nutritional</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 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 working with food suppliers to improve the raw quality of the food provided; sourcing a supplier for high food value and</p>

<p>are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>needs, preferences and the dining experience is improved. The meal satisfaction results have improved.</p>	<p>flavoured pureed foods; initiating moulded shapes for pureed meals; 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. The midday meal provides three main options and two options of desserts. Dinner provides a choice of two options.</p> <p>As a result of these interventions, resident surveys identified an improvement in meal satisfaction in the 2017 survey. Rest home resident score in 2016 was 3.93 and in 2017 4.20. There was a decrease in the hospital resident survey of 3.82 in 2016 to 3.60 in 2017. The hospital relative response had improved from 3.88 in 2016 to 3.90 in 2017. The decrease in resident survey was identified due to the number of residents unable to participate therefore their relatives were the advocates. The service has achieved an improved satisfaction with the meals provided.</p>
---	--	---	--

End of the report.