

Rowena Jackson Retirement Village Limited - Rowena Jackson 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:

Legal entity:	Rowena Jackson Retirement Village Limited
Premises audited:	Rowena Jackson Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 April 2018 End date: 17 April 2018
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:	144



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

General overview of the audit

Rowena Jackson facility is part of the Ryman group, providing care for up to 155 residents in the care centre and up to 15 residents at rest home level in serviced apartments. On the day of audit, there were 144 residents including six 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 nurse practitioner.

The village manager has been in the role for over 13 years. She is supported by an assistant manager and clinical manager. The management team is supported by the Ryman management team including the 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, health and safety programme, activities, food service, laundry service, restraint free environment and infection surveillance.

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. Rowena Jackson 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. Rowena

Jackson provides clinical indicator data for the three services being provided (hospital, rest home and dementia care). 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

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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The service has a comprehensive admission pack. The systems reviewed evidenced each stage of service provision was developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a range of life experiences and choices. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs. Residents' clinical files reviewed validated the service delivery to the residents. Where progress was different from expected, the service responded by initiating changes to the specific care plan. Allied health professionals are involved in the resident's care as applicable

Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files evidenced individual activities were provided either within group settings or on a one-on-one basis.

There was an appropriate medicine management system in place. Staff responsible for medicine management attended medication management in-service education and have current medication competencies. The residents who self-administer medicines do so according to policy.

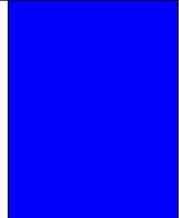
All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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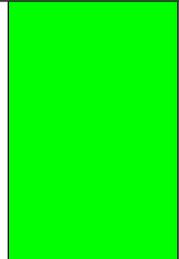
The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy 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.		All standards applicable to this service fully attained with some standards exceeded.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents using restraints and two 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.
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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 (registered nurse) 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. The service engages in benchmarking with other Ryman facilities.

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	3	43	0	0	0	0	0
Criteria	7	87	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information related to the Code is made available to residents and their families. Twenty care staff (four unit-coordinators, four registered nurses (RNs) and 12 caregivers across each area) interviewed, confirmed their understanding of the Code and how it is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Written information on informed consent is included in the admission agreement. The clinical staff reported informed consent is discussed at the time the resident is admitted to the facility and when additional consent requires to be obtained, such as flu vaccinations. Copies of legal documents such as enduring power of attorney (EPOA) for residents are obtained, where residents have named EPOAs and these were reviewed on fifteen residents’ files (three dementia including one respite, six rest home including one from the serviced apartments and one respite resident, and six hospital files including one respite resident). Residents and family interviewed confirmed they have been made aware of and understand the principles</p>

consent.		of informed consent and have received information, so they can make informed choices and decisions that affect their lives. Staff interviewed demonstrated a good understanding of informed consent processes. Advance directives are recorded and located on residents' files.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks. Advocacy information is displayed. Residents and family have access to Age Concern representatives.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend community events outside of the facility including stroke club, blind foundation, hearing association. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. The manager stated they are always working on ways to improve community involvement. Relatives and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and visible at the entrance to the facility. 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.</p> <p>There have been nine resident/relative complaints for 2017 (including one received from the HDC) and one complaint (year to date) for 2018. The village manager has responded and met with families as required. The operations manager is involved in the management of HDC complaints. Corrective actions have been implemented and remain in place. The village manager monitors progress of implemented corrective actions with complainants, to ensure the complaints are resolved to the satisfaction of the complainant.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is a welcome pack that includes information about consumer rights. There is also the opportunity to discuss aspects of the code of rights during the admission process. Six relatives (four rest home and two of dementia care residents) and nine residents (four hospital and five rest home) interviewed, confirmed that they have been provided with information on the code of rights. Large code of rights posters is displayed throughout the facility. The village manager and clinical manager reported having an open-door policy and described the process around discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<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>	<p>FA</p>	<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 completed. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with local Iwi and other community representative groups. Family/whānau involvement is recognised and acknowledged by staff. There were no residents who identified with Māori culture. The local Iwi and kaumātua has been involved in the blessing of opening new areas of the facility, such as the front entrance and the new dining room.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered, and that staff take into account their cultural values. The service celebrates cultural days</p>

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		including Matariki, Chinese New Year and Japanese day.
Standard 1.1.7: Discrimination Consumers 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 across all areas confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers 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 at head office by the appropriate person. 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 service has been successful in reducing falls in hospital level residents.
Standard 1.1.9: Communication Service 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. The information pack is available and can be 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 arises. Evidence of families being kept informed is documented in the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Incident/accident documentation reviewed 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.

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Rowena Jackson Retirement Village is a Ryman Healthcare facility. The service provides care for up to 155 residents in the care centre at hospital, rest home and dementia level of care. The 70 beds in the hospital unit are dual-purpose and there are eight beds in the 59-bed rest home that are dual-purpose. There are 26 beds in the dementia care unit. There are 15 serviced apartments certified to provide rest home level of care.</p> <p>On the day of audit, there were 144 residents in total, 53 hospital level residents, 65 rest home residents (including one resident on respite care and six residents in serviced apartments) and 26 residents (including one respite care) in the dementia care unit. All other long-term residents were under the aged related residential care (ARRC) agreement.</p> <p>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 2017 year have been reviewed and 2018 objectives in place. A quality improvement plan register for 2017, documented a number of initiatives and progress updates. There is a comprehensive health and safety, and risk management programme being implemented at Rowena Jackson.</p> <p>The village manager (RN) has been in this role for thirteen and a half years and has had a total of 18 years involvement in older persons health. The village manager is supported by a full-time experienced clinical manager who has been in the position for five years. She is supported by a hospital unit coordinator, rest home unit coordinator, dementia unit coordinator and serviced apartments unit coordinator. Management are supported by a regional manager and operations and clinical manager, who were present during the audit.</p> <p>The village manager attends the annual Ryman managers conference and manager forums and the clinical manager has attended a Ryman leadership programme and clinical seminars in 2017 and 2018.</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>	<p>FA</p>	<p>The clinical manager is responsible during the temporary absence of the village manager, with support provided from the assistant manager and 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>	<p>FA</p>	<p>Rowena Jackson 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. Audit summaries and quality improvement plans (QIP) are completed where a non-compliance is identified. QIPs reviewed for 2017 and 2018 have been closed out once resolved. The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and displayed in the staff room, showing trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>The resident satisfaction survey was completed in May 2017 with a high overall satisfaction rate. Quality improvement plans were implemented evidencing that suggestions and concerns were addressed.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (senior caregiver) was interviewed. He has completed external health and safety training including a diploma in occupational health and safety and e-learning health and safety education. 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. Rowena Jackson has recently completed a major refurbishment programme and the service implemented a comprehensive plan to manage the associated risks and keep staff, residents and visitors safe. The area under construction was cordoned off safely. In conjunction with this, there has been an emphasis on health and safety with increased staff involvement. Ryman has achieved tertiary level ACC in the accredited employers programme, expiry 31 March 2019.</p> <p>The service has achieved a continuous improvement rating around identifying risks and managing health</p>
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		and safety.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of eighteen incident/accidents forms identified that all are fully completed and include timely 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. Section 31 reports were sighted for pressure injuries and a recent fracture.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (one clinical manager, two unit-coordinators, two RNs, six caregivers, two 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. Practising 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.</p> <p>There is an implemented annual education plan for 2018. 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. Approximately 70% of CA have attained their National certificate in Aged Care.</p> <p>Seven of 30 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. Education is specific at each monthly Clinical meeting along with journal club.</p> <p>There are currently 12 staff working in the dementia unit – of these 11 have completed dementia standards and one staff member who has not been at the service for six months is enrolled and actively completing the required training.</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>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. Caregivers interviewed across the four units 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 is one rest home unit (Edinburgh), two hospital units (O'Byrne and Salisbury) and one dementia care unit.</p> <p>The serviced apartments are currently managed by an enrolled nurse with oversight from the coordinator based in one of the hospital units. There are 15 serviced apartments certified to provide rest home level of care. There were six rest home level residents living in serviced apartments at the time of the audit. On morning shift there is a unit coordinator working the full shift and two caregivers on short shifts and two short shift caregivers in the afternoon. The staff in the rest home wing provide cover for the late afternoon and night shift.</p> <p>In the Edinburgh rest home unit there are 55 current residents in total (54 rest home and 1 hospital resident). On the morning shift: there is one unit-coordinator (EN), one RN and six caregivers (three long and three short shifts) and a diversional therapist (DT) until 5.00 pm. On afternoon shift, there is one RN, and four caregivers (two long and two short shifts), and on night shift there are two caregivers with oversight from a hospital-based RN.</p> <p>In the O'Byrne hospital wing with 30 current residents, on morning shift there is a unit coordinator (RN), two RNs and eight caregivers (four long and four short shifts), an activities coordinator seven day a week and a fluid assist and physiotherapy assistant from 9.00 am to 1.00 pm. On afternoon shift: there are two RNs, and six caregivers (four long and two short shifts), a lounge shift from 4.00 pm to 8.00 pm and on night shift there is one RN and two caregivers.</p> <p>In the Salisbury hospital wing with 27 current residents (24 hospital and three rest home), on morning shift there is a unit coordinator (RN), two RNs and four caregivers (two long and two short shifts), an activities coordinator seven day a week and a physiotherapy assistant from 9.00 am to 1.00 pm. On afternoon shift: there are two RNs, and four caregivers (two long and two short shifts), and a lounge shift from 4.00 pm to 8.00 pm and on night shift there is one RN and two caregivers.</p> <p>In the dementia care unit there are 26 current residents in total. On the morning shift: there is unit coordinator (RN) five days a week and senior caregiver the other two days, one RN and three caregivers (two long and one short shift) and a DT from 9:30 am to 6.00 pm. On afternoon shift, there is an EN, and three caregivers (one long and two short shifts), and on night shift there are two caregivers with oversight from a hospital-based RN.</p>
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<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. 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.</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>The entry and assessment processes are recorded. Information specific to this service is recorded and communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information including specific information on the dementia care unit.</p> <p>Residents' admission agreements evidenced resident and/or family and facility representative sign off. The needs assessments were completed for rest home, hospital and dementia levels of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner and all relevant admission information was provided and discussed including charges not included in the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There was appropriate communication between families and other providers in the residents' files that demonstrated transition, exit, discharge or transfer plans were communicated, when required. Transition, exit, discharge, or transfer form / letters / plan were located in residents' files, where this was required. One rest home file reviewed demonstrated a seamless admission to the hospital. GP was informed of resident decline, resident was reviewed and admission to hospital was arranged, relative was informed, transfer documentation was completed and copy in file. Registered nurses interviewed describe the process involved on admission and discharge of a resident from hospital including verbal handovers, interRAI, and medication management. Faxes and discharge documentation were on file.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of monthly blister packs is completed by two RNs and any errors fed back to the pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency. Education around safe medication administration has been provided annually. The service uses an electronic medication system. Medications were stored safely in all units. Medication</p>

<p>legislative requirements and safe practice guidelines.</p>		<p>fridges are monitored weekly. All eye drops and creams in medication trolleys were dated on opening. There were two residents self-medicating on the day of audit and both residents had signed medication competencies on file. The medications were adequately stored in resident rooms.</p> <p>Twenty-eight medication charts were reviewed (six dementia, 12 hospital and 10 rest home). Long-term resident medication charts were on the electronic medication system and three 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.</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 delivery.</p>	<p>FA</p>	<p>The qualified head chef is supported by a second chef on duty, cook's assistants and kitchenhands. Staff have been trained in food safety and chemical safety. The newly constructed kitchen is well-equipped with a good work flow. All meals and baking are prepared and cooked on-site. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Project "delicious" has been in place since February 2017. Menu choices are decided by residents (or primary care staff if the resident is not able) and offer a choice of three main dishes for the midday and two choices for evening meal including a vegetarian option. Diabetic desserts and gluten free diets are accommodated. Meals are plated in the kitchen and delivered in hot boxes to each unit satellite kitchen. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident dislikes are accommodated and listed on the daily spreadsheet. Alternative foods are available on the menu or offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are available after hours. There is a supply of snacks in the dementia unit.</p> <p>Freezer and chiller temperatures and end-cooked temperatures are taken and recorded daily. The chilled goods temperature is checked on delivery. Twice daily food serving temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained for the cook and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing. The food control plan has been registered but not yet verified.</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</p>	<p>FA</p>	<p>There is an admission information policy. The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The</p>

<p>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>potential resident would be referred back to the referring service.</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 registered nurse completes an initial assessment and care plan on admission including relevant risk assessment tools. Risk assessments are completed on admission and reviewed six monthly or earlier due to health changes. InterRAI assessments were completed within 21 days of admission as sighted in 12 long-term resident files. Three respite files (one for each service level) contained initial assessments, risk assessments and care plans. The facility has processes in place to seek information from a range of sources, for example, family, GP, specialist, previous hospital discharge documentation and the referrer. The residents' files evidenced residents' discharge/transfer information from the district health board (DHB).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The care plans reviewed were individualised and up-to-date. The residents' files were in hard copy, with all assessments, wound documentation, and monitoring charts recorded on the electronic VCare system. Care plan interventions reviewed reflected the assessments and the level of care required. The long-term care plan is updated to reflect current changes to resident conditions. There was evidence of allied health care professionals involved in the care of the resident, including physiotherapist, podiatrist, dietitian, nurse practitioner for older persons health, geriatrician, and wound care nurse.</p> <p>In interviews, staff reported they received adequate information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented as sighted in current GP progress reports.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a nursing review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and</p>

<p>needs and desired outcomes.</p>		<p>procedures are in place. There was one confirmed pressure injury. The second pressure injury was re-assessed and found to be a cause of friction (both hospital level residents). There is evidence of a wound nurse specialist involvement in wound management. On the day of the audit there were seventeen wounds (four rest home and thirteen hospital level) which included non-healing chronic ulcers, skin tears, lesions and other superficial wounds. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences.</p> <p>There is a suite of monitoring forms available on the VCare system which include weight, vital signs, behaviour monitoring and assessment, pain, neurological observations and blood glucose monitoring.</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>CI</p>	<p>The activities team at Rowena Jackson includes one diversional therapist and eight activities coordinators. Activities are available throughout the facility between 9.30 am and 8.00 pm across seven days a week.</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 can feedback on the programme through the resident and relative meetings and satisfaction surveys.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group, including (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, special days such as St Patricks days and other celebrations.</p> <p>The service has implemented the use of doll therapy which has proven to reduce the incidence of challenging behaviours, falls and the use of antipsychotic medication. Music therapy was introduced to help improve the ambience of the facility and improve dining experiences.</p> <p>In interviews, the activities coordinators confirmed the activities programme meets the needs of the service group and the service had appropriate resources. The diversional therapist and the activities coordinators plan, implement and evaluate the activities programmes. There are activities programmes for each service at the facility. Regular exercises and outings are provided for those residents able to partake. Interviews with residents, family and staff confirmed the activities programme included input from external agencies</p>

		and supported ordinary unplanned/spontaneous activities, including festive occasions and celebrations. There were activities assessments, care plans and care plan evaluations in residents' files reviewed.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly or more often when the resident condition changed. There was evidence of multidisciplinary input in care plan evaluations against the resident goals. Care plans had been updated to reflect any changes in care. Residents and family confirmed their participation in care plan evaluations. The GP reviews the residents at least three monthly or earlier as required.
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. 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. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with	FA	The single storey building accommodates a care centre and serviced apartments. The building has a current warrant of fitness that expires 16 November 2018. The head of maintenance oversees maintenance and repairs. All requests are recorded in a register held

<p>an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>at the main reception (sighted) which has been signed off as requests have been addressed. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, electrical testing (bi-annually) of electric beds and hoists and electrical testing. 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 stable below 45 degrees Celsius. The rest home lounge and dining area have been renovated and refurbished as well as the 40-bed dual-purpose unit. The front entrance has been refurbished and includes a café near the front entrance.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the rest home and hospital wings for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.</p> <p>There is a team of grounds and garden staff that maintain the external areas. Residents are able to access the outdoor gardens and courtyards safely from both wings. Seating and shade is provided.</p> <p>The dementia unit has a safe internal courtyard with entry/exit points from the lounge and conservatory. Seating and shade is provided. A second safe outdoor area had raised garden beds that are tended to by the residents.</p> <p>Staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including; sensor mats, standing and lifting hoists, hospital lounge chairs, mobility aids, transferring equipment and pressure relieving mattresses and cushion.</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. There is a mix of bedrooms with full ensuites, toilet and hand basin ensuites and shared bathrooms (between couples). There are adequate numbers of communal toilets (located near the communal areas) and shower rooms. Communal toilets have privacy slide signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>All residents' rooms are spacious enough to allow care to be provided safely and for the safe use and manoeuvring of hoists in dual-purpose rooms. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The two dual-purpose hospital wings have a large open plan dining and lounge area. Both units have a family room with tea making facilities. The rest home unit has a large lounge with a smaller second lounge and dining room. Rest home residents in the serviced apartments can choose to dine in the serviced apartment dining room, their own apartment or rest home dining room. The dementia care unit has a large separate lounge, main dining room and smaller dining room, activities room and quiet lounge as well as several seating alcoves around the facility.</p> <p>The service has a library service, hairdressers and shop for all residents to access.</p> <p>The communal areas including the grounds and internal courtyards, are easily accessible.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the internal audit 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 5.00 pm daily with two laundry staff. Material safety datasheets are readily accessible.</p> <p>There are designated cleaning persons on duty each day. Cleaners' trolleys (sighted) were well equipped and stored in locked cupboards when not in use. All chemical bottles have the correct manufacturer's labels. Residents interviewed state they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits. The service has been successful in reducing the amount of unlabelled/missing clothing.</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. Staff have attended emergency and disaster management training and six-monthly fire drills. There is a first aid trained staff member on every shift and accompanying residents on outings. There is an approved fire evacuation plan dated 18 January 2006. The updated fire plan to include the newly constructed areas has been submitted for approval. There are sufficient civil defence kits in the facility and adequate water storage on-site, and food for at least three days. There are four generators to cover the care centre and the village. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (five BBQs) and a generator available in the event of a power failure. The facility is</p>

		secured at night. There are calls bells in all resident rooms, toilet/shower areas and communal areas.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is underfloor heating throughout the facility. The service has consulted an electrician regarding individually thermostat-controlled switches in all resident rooms. All rooms have external windows with plenty of natural sunlight. Residents and relatives confirmed satisfaction with the temperature of the facility.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is a registered nurse with a job description that defines the responsibility of the role. The infection prevention and control committee are combined with the health and safety committee, which meets two monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and a six-month analysis completed by the infection control and prevention officer which is reported to the governing body.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine.</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 including kitchen and cleaning staff. The infection control officer has completed an infection control study with the DHB, May 2017 and March 2018, that covered infection prevention and outbreak management. The infection and prevention officer 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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection</p>

<p>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>prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits six monthly. 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 Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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 control and prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. There is close liaison with the GPs and the 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. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility. The service has been successful in reducing the number of urinary tract infections (UTI).</p> <p>There have been two confirmed norovirus G11 (inter gastro bug) outbreaks in 2017 (January and July). Relevant authorities were notified. Daily case logs and correspondence were sighted. Staff were debriefed following the outbreaks. Corrective actions implemented including staff education have been implemented and maintained.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents using restraints and two hospital residents using enablers. The resident files for the residents using enablers (two lap belts) 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. The service is to be commended for maintaining a restraint-free environment for over six years.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p> <p>Rowena Jackson has been restraint free since 2013. The acuity of residents has increased since 2013, and family of residents have expectations of restraint to prevent falls. In January 2017, the service implemented an action plan to maintain the restraint-free environment.</p>

Specific results for criterion where corrective actions are required

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

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

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

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>In September 2017 the service identified an improvement was required around reduction of falls in hospital residents which rose to 11.1/1000 bed nights in June 2017. The service has been successful in reducing falls rates to below the upper limit of</p>	<p>To achieve falls reduction in hospital level residents a falls champion was appointed. All falls are fully investigated, medical causes identified and treated, location and timing of falls analysed for trends and ongoing education includes manual handling, hoist refreshers, intentional rounding and use of equipment such as sensor mats, physiotherapy input and encouragement in exercise programmes. Case studies are discussed at clinical meetings. General practitioners are notified of falls and a medical review including medication review is completed. Care plans record falls prevention strategies that reflect the residents falls risk.</p> <p>The service has achieved its goal in reducing falls in hospital level residents from 11/1000 bed nights in August 2017 to 2.5/1000 in November 2017. The falls rate has remained closer to the lower limit of 2.5/1000 bed nights. An increase to 8.6/1000 bed nights in February 2018 (while under the upper limit for falls) was due to transfer of new residents into the facility. The service continues to review individual strategies for these residents.</p>

		falls at 11/1000 bed nights.	
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	CI	<p>Rowena Jackson demonstrated a culture of preventing harm to residents, visitors and staff through a robust health and safety programme. A continuous improvement plan has been implemented identifying opportunities to improve safety, minimise risks and improve hazard management. One example of this is the implementation of a refurbishment plan to ensure the safety of residents, staff and visitors.</p>	<p>The aim of the project was identified, and an action plan developed. Residents staff and visitors were fully informed throughout with evidence of memo's, meetings and hazard identification resolution plans. The project initially focused on the refurbishment plan which was successfully completed without injury in 2017. It was then expanded to maintain the higher focus on health and safety throughout the village. In January 2018, a "Stop, Think, what could go wrong" project was implemented. Posters were displayed throughout the village promoting the use and location of the near miss book, hazard register, emergency flip charts, infection control flip charts, civil defence equipment and local emergency information. As part of the "Stop, Think, what could go wrong" project, all staff received a prompt card. Staff were encouraged to identify all tasks where potential injuries could occur and document them for further investigation by the health and safety committee. Additional hazard education was provided at the January staff meeting. All health and safety staff have completed a specific induction book. Rowena Jackson has a health and safety library and a health and safety newsletter. The newsletter is distributed three monthly with educational opportunities, hoists key training and bullet points, encouraging influenza vaccinations and discussion regarding recent injuries. Evidence of the success of the project is evidenced in the falls reduction (link 1.1.8.1) restraint free status (link 2.1.1.4) and the reduction in staff incidents. With a workforce of 190 staff, incidents have reduced from 21 incidents in April 2017 to below 15 per month from July onwards and continuing to trend downwards.</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>Ryman has introduced a number of systems to ensure residents nutritional needs are met and the dining experience improved. This has been achieved with the introduction of project “delicious” and acceptable background music during meal times.</p>	<p>An action plan was developed, that included a glossary of terms used in the menu printed on the back, so caregivers and residents could relate to the meals to be able to make informed choices; consistent meal presentation with meals being served and plated by chefs/cooks in the kitchen (observed); large menu boards able to display the full daily menu; encouraging residents to provide written feedback in communication books and the chef visiting dining rooms for feedback on meals. The ambience of dining was improved with ensuring dining rooms were set up nicely, staff available to assist, classical background music (link CI 1.3.7.1) and a relaxed rather than rushed meal time with residents able to chat and stay longer in the dining room.</p> <p>As a result of these interventions there has been an improvement in resident satisfaction evidenced through meeting minutes, comments in the communication book in the dining rooms, letters and cards written to the chefs/cooks (sighted), positive feedback at resident meetings (sighted), some residents gaining weight since project delicious commenced and residents sitting longer over their meals.</p> <p>The resident/relative satisfaction survey for 2018 is in the process of being collated. Preliminary results for the hospital resident and relative surveys demonstrate an increase in satisfaction with meals and the meal service. There have been no complaints in relation to food in 2017 and 2018 to date.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>An education session in 2015, demonstrated the use of doll therapy reduced challenging behaviours and the need for antipsychotic medication for residents with dementia. The service introduced doll</p>	<p>Prior to introducing doll therapy, consent was obtained by the relatives who were fully informed of the benefits of doll therapy. Strict guidelines were put in place around the management of this to protect the dignity of residents. Doll therapy is only effective if the resident believes the doll is a real baby, and their response is to provide comfort to them. Baby George and baby Mohammed were introduced to residents who displayed particularly aggressive behaviours and who were frequently agitated. The use of doll therapy has meant that residents have been given a purpose in being a carer for their baby. This purpose has reduced the triggers and causes of previous agitated and aggressive behaviours. There is documented evidence of reduced behaviours (recorded on behaviour charts) and a significant reduction in the use of antipsychotic medications as sighted on medication charts. Resident mood has improved, with staff reporting the resident appears more content and happy throughout the course of the days. This sort of positive outcome for the</p>

		<p>therapy in June 2016 for three residents (two hospital level and one dementia care resident). The doll therapy has been effective in reducing challenging behaviours.</p> <p>A second initiative was to implement music therapy throughout the facility, of resident's choice, to improve the ambience for residents, relatives and guests to the facility. The staff utilised a new music selection that is relevant to the era, and to the activities or entertainment that is happening. Another aim was to provide a more relaxed atmosphere in</p>	<p>resident has ensured the reduction in episodes of challenging behaviours is maintaining both dignity and ensuring more social acceptance in communal areas. Utilisation of 'as required' antipsychotics has reduced from an average of 20 administrations over a four-week period to only seven administrations in any four-week period between June and December 2016 for residents with doll therapy. A third resident also had a reduction of medications and behaviours as documented, which has led to a reduction of zero falls since starting the therapy. The introduction of doll therapy has been successful in reducing behaviours, antipsychotic medications and falls.</p> <p>The service introduced site-wide music tailored to resident choice to improve the level of enjoyment and ambience of the newly refurbished communal areas. Residents were surveyed, and a list of suitable genre background music was compiled and played throughout the day. Activities staff confirmed the music provided a relaxing atmosphere with spontaneous outbreaks of residents singing. General feedback has shown guests and relatives are feeling welcome when entering the facility. The activities team has seen residents' engagement when a song or a style of music resonates with individuals. This was observed in the dementia wing and included observing a husband and wife enjoying a dance in the lounge. A survey in March 2018 was initiated for residents, relatives, guests, staff and contractors to determine whether the new music system was being favourably received. Results of the survey showed 95% of participants liked the music, and felt the volume was just right throughout the day and 29% of participants felt happy, 32% felt relaxed and 21% reported feeling positive. Interviews with staff, residents, and relatives confirmed they enjoyed the music therapy.</p>
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		the dining rooms, recreation areas and lounges.	
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	<p>A continuous improvement project was commenced in January 2017 to increase resident and relative satisfaction with laundry services. Missing/lost clothing items had been identified as a resident/relative concern in resident meetings.</p>	<p>The laundry project aimed to reduce missing/un-named clothing, return clothing to residents within a timely manner and reduce complaints around laundry services. Each resident was provided with individually labelled laundry bags for their personal clothing. The purple resident clothing bags were seen in resident ensuites. The organisation purchased a labelling machine and the laundry persons labelled all resident personal items on admission and as required. Staff received training on the new labelling machine and laundry processes. The laundry person interviewed on the day of audit, could describe the procedure for reducing the amount of missing clothing. Residents and relatives were informed of the labelling procedure. Ongoing discussions at the resident meetings and laundry audits evidenced an improvement in laundry procedures. There is photographic evidence of un-named/unclaimed clothing prior to the project and following the basket introduction of the labelling process. On the day of audit there was a small laundry tray of un-named clothing that had been collected over a three-week period. There have been no complaints in 2017 or 2018 to date in regard to laundry services. The service has been successful in reducing the amount of un-named/missing clothing with zero complaints since the January 2017. The preliminary satisfaction survey results demonstrate an increase in resident/relative satisfaction with laundry services.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Surveillance is completed monthly for all infections that meet standard definitions. Surveillance data is made available for all staff and</p>	<p>The service identified an improvement around reducing UTI rates in August 2017, due to hospital rates being 11/1000 bed nights and an increase in UTIs in the rest home where previous rates had been below the upper limit of 1.5/1000 bed nights. An action plan included additional fluid rounds, jugs of water in rooms, a focus on symptoms management rather than reliance on urine dipstick results, fluid assistant to assist residents with fluids, fluids in other forms over hot weather months, reminders at handovers regarding resident hydration, ongoing education around hand hygiene/personal cares and continence management.</p> <p>The service has been successful in reducing UTIs in the rest home below the</p>

		discussed at facility meetings. Benchmarking occurs against the organisational quality indicators for infections. The service has been successful in reducing UTIs below the upper limit for rest home and hospital residents.	upper limit of 1.5/1000 bed nights from 1.14 to 0.55 and zero bed nights over the last eight months. The hospital UTI rates have dropped below the upper limit ranging from 1.5 to 0.54/1000 bed nights over the last eight months. This has reduced the need for antibiotics, reduced potential delirium and related falls (link 1.1.8.1).
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint</p>	CI	<p>The service is to be commended for maintaining a restraint free environment despite increasing resident acuity. This project has eliminated the risks associated with restraint while maintaining or improving clinical indicators for falls (link 1.1.8.1) and challenging</p>	<p>Rowena Jackson has been restraint free since 2013. The acuity of residents has increased since 2013, and family of residents have expectations of restraint to prevent falls. In January 2017, the service implemented an action plan to maintain the restraint-free environment. The plan included staff education, monthly enabler and restraint, reporting, meetings with family who request restraint, embed alternative strategies to restraint, use of the delirium screening tool to identify reversible changes in behaviour, liaison with the GP and medication reviews and appointment of a falls champion. Evidence of communication with two families identified alternative strategies with implementation of these strategies, avoiding the need for restraint. The restraint register evidences that restraint has not been used at Rowena Jackson for six years and during this time the falls rate has continued to trend down and is consistently below the average for the Ryman group.</p>

<p>evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>behaviour rates.</p>	
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End of the report.