

Malvina Major Retirement Village Limited

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:	Malvina Major Retirement Village Limited
Premises audited:	Malvina Major Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 August 2018 End date: 15 August 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:	116

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

Malvina Major facility is part of the Ryman group providing care for up to 116 residents in the care centre and up to 20 residents at rest home level in serviced apartments. On the day of audit, there were 116 residents including four residents in the serviced apartments.

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

The village manager is supported by an assistant to the manager and clinical manager. The management team is supported by the Ryman management team including regional manager.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Residents and relatives interviewed commented positively on the care and services provided at Malvina Major.

There was one area identified for improvement at this audit regarding care plan documentation.

The service is commended for achieving continuous improvement ratings around good practice, reduction of challenging behaviours, activities, food service, laundry service 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. 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 and 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. Malvina Major 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. Malvina Major provides clinical indicator data for the two services being provided (hospital and rest home). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has 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 reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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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 development and review. Residents' clinical files reviewed validated the service delivery to the residents. Allied health professionals are involved in the resident's care.

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 general practitioner reviews the medications at least three monthly.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. 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.

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

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

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.

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.

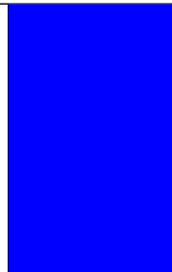


Standards applicable to this service fully attained.

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 nine residents with twelve restraints and two residents using 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.



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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (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	5	44	0	1	0	0	0
Criteria	6	94	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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. Twelve care staff (three unit-coordinators, one registered nurse (RN), six caregivers and two activities coordinators) interviewed, confirmed their understanding of the Code and how it is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and was last completed in November 2017.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>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 and permission granted for general consent is included in the admission agreement. The RNs interviewed 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 influenza vaccinations. Informed consent and copies of legal documents such as Enduring Power of Attorney (EPOA) for residents were sighted on 11 resident files reviewed including five rest home (including one from the serviced apartments and one respite resident) and six hospital (including private paying respite resident).</p>

		Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent and have received information, so they can make informed choices and decisions that affect their lives. Care staff interviewed demonstrated a good understanding of informed consent processes. Advance directives are recorded and located on residents' files.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks. Advocacy information is displayed. Residents and family have access to Age Concern representatives.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. The village 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.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	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 six complaints made in 2017 and ten complaints received in 2018 year to date, including one from the district health board (DHB). The complaints reviewed included follow-up meetings and letters, resolutions were completed within the required timeframes as determined by the Health and Disability Commissioner. The DHB complaint was investigated, followed up and closed off by the DHB in May 2018. The operations manager is involved in the management of HDC or DHB complaints. 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>	FA	<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. Seven relatives (three rest home and four hospital) and seven residents (four rest home and three hospital) interviewed, confirmed that they have been provided with information on the code of rights. Large code of rights posters are displayed throughout the facility. The village manager and clinical manager reported having an open-door policy and described the process around discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<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 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. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect, which was last completed in June 2018.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. There was one resident who identified as Māori at the time of the audit. The resident's file was reviewed and included Māori cultures and preferences. Links are established with local iwi and other community representative groups. Family/whānau involvement is recognised and acknowledged by staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate, are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered, and that staff consider their cultural values.</p>

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
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	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly 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 for collating, monitoring and benchmarking between facilities.</p> <p>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.</p> <p>The service has a number of allied health professionals involved in the care of the residents. The service has developed a good working relationship with the local hospice team and are known for their excellence in end of life care. Malvina Major has become the preferred provider for end of life care, which has been demonstrated by the increase in referrals from hospice.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>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.</p> <p>Regular contact is maintained with family, including if an incident or care/health issues arises. Evidence of families being kept informed is documented in the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Incident/accident documentation reviewed</p>

		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>	FA	<p>Malvina Major is a Ryman Healthcare retirement village. The service provides rest home and hospital level of care for up to 136 residents in total, with 116 residents in the care centre and 20 serviced apartments certified as suitable to provide rest home level care. There are 58 rest home beds on the first floor and 58 hospital beds on the second floor. At the time of the audit there were 116 residents in total, 112 residents in the care centre, 58 rest home residents including two residents on respite care and 54 hospital level residents including two residents on respite care. There were four rest home residents in the 20 serviced apartments. All residents are under the ARCC contract.</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 are in place. A quality improvement plan register for 2017/2018, documented a number of initiatives and progress updates. There is a comprehensive health and safety, and risk management programme being implemented at Malvina Major.</p> <p>The village manager has been in the position since May 2016 and is a registered nurse with a current practising certificate. She is supported by a clinical manager who has also been in the position since October 2016 and an assistant to the manager, who has been in the position for one year. Management are supported by a hospital unit coordinator/RN, rest home unit coordinator/RN, serviced apartment unit coordinator/EN, a regional manager, operations/clinical manager and operations support/project leader (who was 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</p>	FA	<p>The clinical manager is responsible during the temporary absence of the village manager, with support provided from the assistant to the manager and regional manager.</p>

services to consumers.		
<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>Malvina Major 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. The resident satisfaction survey was completed in February 2018 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 (activities coordinator) was interviewed. She has completed external health and safety training level one. Health and safety meetings are conducted monthly. Risk management, hazard control and emergency policies and procedures are in place. There is a stop and think health and safety campaign with staff completing cards identifying risk ratings and controls. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at management and staff meetings. Ryman has achieved tertiary level ACC in the accredited employers programme, expiry 31 March 2019. Falls prevention strategies are in place that include; ongoing falls assessment, reviewing call bell response times, routine checks of all residents specific to each resident's needs (intentional rounding), encouraging resident participation in the activities programme and the use of sensor mats and night lights.</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. A review of fifteen incident/accidents forms for July 2018 identified that all are fully completed and include timely follow-up by a RN. Neurological observations were completed for seven unwitnessed falls of for a suspected injury to the head. 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. The village manager was able to identify situations that would be reported to statutory authorities. One section 31 notification report was sighted for a stage four pressure injury (non-facility acquired) in February 2018. An outbreak in November 2017 was notified to the public health authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (one clinical manager, three unit-coordinators, two RNs, four caregivers, one activities coordinator, one head chef and one maintenance person) 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 80% of caregivers have attained their national certificate in aged care. Ten of twenty 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 the journal club.</p>
<p>Standard 1.2.8: Service</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 stated that management are supportive</p>

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>and approachable, and that there are sufficient staff on duty at all times. The village manager and clinical manager both work 40 hours per week. In the rest home unit there were 58 of 58 residents in total. On the morning shift: there is one unit-coordinator (RN), one RN and seven caregivers (four long and three short shifts). On the afternoon shift, there is one RN, and four caregivers (two long and two short shifts), and on the night shift there are three caregivers with oversight from a hospital-based RN.</p> <p>In the hospital unit there were 54 of 58 residents in total. On morning shift there is a unit coordinator (RN), three RNs and twelve caregivers (seven long and five short shifts). On afternoon shift: there are three RNs and nine caregivers (four long and five short shifts), and on the night shift there is one RN and three caregivers. There are 20 serviced apartments certified to provide rest home level of care. There were four rest home level residents living in serviced apartments at the time of the audit. On morning shift there is a unit coordinator (EN) with oversight by the clinical manager and two caregivers and one caregiver on the afternoon shift. The staff in the rest home wing provide cover for the late afternoon and night shift. Interviews with residents and relatives confirmed that there are sufficient staff on duty.</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. 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.</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 the services and levels of care.</p> <p>Residents' admission agreements evidenced resident and /or family and facility representative sign off. Residents and family interviewed 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. The respite care residents had signed short-term agreements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</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,</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>exit, discharge, or transfer form/letters/plan were located in residents' files, where this was required.</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 current medication guidelines. Medication reconciliation of monthly blister packs is completed by RNs and the back of the blister pack signed. Any errors are fed back to the pharmacy. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency. Education around safe medication administration has been provided annually. The service uses an electronic medication system. Medication fridges are monitored weekly. All eye drops and creams in medication trolleys were dated on opening. There are monthly checks of all medication expiry dates and oxygen cylinders. There were two hospital residents self-medicating on the day of audit and both residents had signed medication competencies on file.</p> <p>Twenty-two medication charts were reviewed (12 hospital and 10 rest home). 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 and the progress notes. The GP receives INR results for residents on warfarin and the GP prescribes the dose directly 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>CI</p>	<p>There is a food service manager who is supported by a head chef, second chef, cooks' assistants and morning and afternoon kitchen assistants. Staff have been trained in food safety and chemical safety. The service has a food control plan that expires 9 May 2019. 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 implemented since January 2017. Meals are plated in the kitchen and delivered in hot boxes to each unit satellite kitchen. Special diets such as halal, gluten free and soft diets are labelled. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. Cultural, religious and food allergies are accommodated.</p> <p>Freezer and chiller temperatures and end cooked, and re-heating temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. All foods were date labelled and decanted goods are checked for expiry dates three monthly. A cleaning schedule is maintained for the cook and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing. The</p>

		<p>kitchen has been renovated to improve the work flow, design and storage areas.</p> <p>Residents can provide feedback on the meals through resident meetings, 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>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. The resident would be referred back to the referring service if the level of care could not be provided or there were no beds available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The registered nurse completes an initial assessment 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 nine long-term resident files. Two respite files (one for each service level) contained initial assessments risk assessments. The outcomes of assessments are used to form the basis of the MyRyman care plans (link 1.3.5.2). 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 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>	PA Low	<p>The care plans reviewed were individualised on the MyRyman system, which were accessible in the resident rooms. Not all MyRyman long-term care plans reviewed reflected the resident's current health status. The care plans identify resident goals. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian, 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. A paper-based care plan acknowledgment form is signed by resident/relatives.</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>When a resident's condition alters, the registered nurse initiates a nursing review and if required, GP, nurse specialist consultation. There is documented evidence in the electronic progress notes 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 procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for three residents with wounds and recorded on the electronic VCare system. There were three residents with pressure injuries (two stage one and two stage two). One resident was admitted with two pressure injuries. The facility has an RN/wound champion who reviews wounds at least weekly and on request. There is access to a wound nurse specialist at the DHB if required.</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 includes 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>There are two activity coordinators employed 35 hours per week to coordinate and implement the Engage programme. The programme is Monday to Friday in the rest home and Monday to Sunday in the hospital. A weekend coordinator is based in the hospital for weekend activities.</p> <p>The Engage programme has set activities with the flexibility 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, make and create, men's group, sensational senses, walking groups, 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, church services and other celebrations.</p> <p>Community visitors include regular entertainers, church visitors, pre-school children, high school students, work placement students, library service and visiting pet therapy dogs (including those pets of the staff and GP). There are twice weekly outings and scenic drives for rest home and hospital residents. A mobility van is hired for hospital residents.</p>

		<p>Music is enjoyed in a variety of ways including weekly music appreciation for which the service has been awarded a continuous improvement rating.</p> <p>Resident life experiences and activity assessments are completed for residents on admission. The paper-based 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 monthly resident meetings in each unit and relative meetings and satisfaction surveys. Residents/relative interviewed were very happy with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' electronic files evidenced the residents' care plans had been evaluated six monthly or more often when the resident condition changed. There was evidence of multidisciplinary (MDT) input in care plan evaluations against the resident goals. The MDT review includes input from the RN/primary caregiver/physiotherapist/DT, GP and resident as appropriate. The family are invited to attend and are informed of changes as evidenced in the correspondence file in the electronic resident record. The care plans had been updated to reflect any changes in care (link 1.3.5.2). Residents and family confirmed their participation in care plan evaluations. The GP reviews the residents at least three monthly or earlier as required. Regular GP reviews occurred as sighted in current GP progress reports.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected</p>	FA	<p>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.</p>

<p>from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current warrant of fitness that expires 20 November 2018. The service is divided into two units on two levels with the rest home on the ground level and hospital on the second level. There are serviced apartments on the second and third level. There is a nurses' station within each unit.</p> <p>There is one full-time and one part-time maintenance person who report to the property manager. Daily maintenance requests are addressed and signed off (sighted). There is a 12-monthly planned maintenance schedule in place, which includes the calibration of medical equipment and functional testing of electric beds and hoists. All electrical equipment has been tested and tagged annually. Hot water temperatures are monitored and recorded monthly with documented corrective actions for temperature recordings above 45 degrees Celsius. Contractors are available 24/7 for essential services.</p> <p>The addition of an on-site café has provided an area for residents/relatives to socialise over coffee and morning tea/light lunches. Environmental improvements include upgrading the atrium with re-glazing, re-roofing and insulation making the area warmer in winter and cooler in summer, refurbishment of the care centre and replacement of lounge chairs, new on-site hair salon, upgraded disability toilet, new call bell system and upgraded library area.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space around the facility for storage of mobility equipment. Rest home and hospital residents have access to the atrium and the communal grounds and gardens, which are well maintained. The service employs grounds and garden staff who maintain the external areas. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided.</p> <p>Staff interviewed stated 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 cushions and weigh scales.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are</p>	<p>FA</p>	<p>All bedrooms are single. Resident rooms have ensuites and there are communal toilets located near communal areas. Communal toilets have privacy signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	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>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>Both the rest home and hospital units have a large dining room and kitchenette. There are large lounges in each unit, a family/whānau room in the rest home and a second lounge in the hospital. A reflection room is available for communal use and for church services. A large Burma lounge is available for communal use and often used to host functions and meetings such as music appreciation evenings.</p> <p>The communal areas including the hair salon and café internal courtyards are easily accessible. Some resident rooms open out onto the atrium.</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>	CI	<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 underwent an upgrade that improved the workflow of the laundry with a defined clean and dirty laundry area, new equipment and linen storage areas. There are designated laundry persons who operate the laundry from 8.00 am to 10.00 pm daily. All linen and personal clothing is laundered on-site. A labelling machine was installed to reduce the amount of un-named/missing clothing items. The service has been successful in reducing the amount of unlabelled/missing clothing.</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. Cleaners carry chemicals in caddies into the resident's room for cleaning. Residents interviewed stated 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</p>

		audits.
<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 is an emergency and disaster management plan in place to guide staff in managing emergencies and disasters. Staff emergency and disaster management training is booked for 22 August 2018. There is a first aid trained staff member on every shift and accompanying residents on outings. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 18 May 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked six monthly.</p> <p>Sufficient water is stored for emergency use and alternative heating and cooking facilities (BBQs) are available. There is an approved fire evacuation plan dated 9 July 1998. The updated fire plan to include the newly renovated areas has been submitted for approval. There are two generators to cover the care centre and the village if there is a power failure. Smoke alarms, sprinkler system and exit signs are in place. The facility is secured at night. There are call bells in all resident rooms, toilet/shower areas and communal areas. Visitors and contractors sign in at reception when visiting.</p> <p>Visitors and contractors sign in at reception when visiting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is radiator heating in resident rooms with individual thermostat controls. The service has improved the lighting, heating and ventilation within the facility. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme are 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 linked to the quality system.</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 infection control education including DHB study day, Ryman annual infection control conference and skype conference with a microbiologist.</p> <p>The infection control 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 procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management. Infection control education is provided both at orientation and as part of the annual training schedule. All staff complete annual hand hygiene audits. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>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 programme.</p>	<p>CI</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Data is analysed for trends and corrective actions. Staff are informed of infection control matters 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 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 respiratory infections across the care centre.</p> <p>There has been one norovirus outbreak in November 2017. Relevant authorities were notified (sighted). Daily case logs and correspondence were sighted. The service received a letter of commendation from the regional public health.</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. At the time of the audit, there were nine residents with twelve restraints (eight bed rails and four chair briefs) and two residents using enablers (bed rails). The files for the two residents using enablers reflects a restraint/enabler assessment and voluntary consent by the resident. Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (hospital unit coordinator/RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The files for three residents using six restraints (three bed rails and three chair briefs) were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Assessments identify the specific interventions or strategies trialled before implementing restraint. 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 monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify one hourly checks were evidenced on the monitoring form for the three resident files where restraint was in use. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in the three resident files where restraint was in use. Restraint use is discussed in the RN meetings. This was confirmed in the meeting minutes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>The MyRyman electronic resident care system is available in all resident rooms. The care plans include resident goals and support/interventions to meet the resident needs, however not all care plans reflected the resident's current health status.</p>	<p>Three resident MyRyman care plans (two hospital and one hospital respite care) did not include support/interventions as follows: 1) there was no pain management plan for identified pain for one respite care resident and there were no documented interventions for shortness of breath as per the hospital discharge plan, 2) there was insufficient detail regarding pain location and management and 3) there was no documented pain management plan for one resident who identified wound pain as per the wound assessment.</p>	<p>Ensure the MyRyman care plans are updated to reflect the resident's current health status including pain management.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service is committed to providing high quality end of life care. The service has received more than double the referrals from hospice in 2018 to date than for 2017.</p> <p>In January 2017 the service identified an improvement was required around a high number of incidents of challenging behaviour in the care centre.</p>	<p>Malvina Major Malvina strives to be an excellent provider of end of life care. To achieve this the service have implemented the following a) developed an excellent working relationship with Mary Potter Hospice and GPs, b) developed a palliative care champion for the service, c) continuing education and hosting of palliative care sessions at Malvina Major, d) accessed new innovative funding for RNs to participate in the link-nurse programme whereby the RNs work alongside experienced practitioners at the hospice for five days, e) weekly palliative care rounds at Malvina Major with the palliative care nurse specialist and f) the hospice doctors and nurse specialist have access to the one chart for prompt symptom management. There continues to be effective and regular communication with families. The service links to many areas of palliative care resources and host events and conferences, and attends meetings and reviews palliative care objectives in consultation with hospice and other community agencies. Complimentary letters, cards and emails were sighted from families, allied health professionals and hospice. The number of referrals from hospice have increased from 27 in 2018 for the period of January to August and for the same period for 2017 were 11. The service has achieved the aim of preferred provider of choice for palliative care.</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. One QIP reviewed, reflected a reduction in resident's incidents of challenging behaviour in the care centre.</p>	<p>The achievement of the rating that the service provides an environment that encourages managing and analysing quality data beyond the expected full attainment. The service has conducted a number of QIPs where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.</p> <p>In January 2017 the service identified an improvement was required around a high number of incidents of challenging behaviour in the care centre. A QIP was developed, which included strategies and actions to reduce the number of incidents of challenging behaviour in the care centre. The plan has been reviewed monthly and discussed at clinical staff meetings. The service has been successful in reducing and better managing incidents of challenging behaviour within the care centre. A review of the data for the period from January 2017 ending in June 2018, evidenced a reduction from 5.6 incidents of resident challenging behaviours in January 2017 to 1.0 in June 2018.</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 which was launched in 2016.</p>	<p>The four-week rotating seasonal menu offers a variety of choices including three main dishes for the midday and two choices for the evening meal, including a vegetarian option. Gluten free meals are offered on the menu. The service accesses specialised pure foods for pureed options and use in dishes such as soups, which adds higher food value for those at risk of weight loss. Other initiatives include an easy to read laminated menu card for ease of weekly ordering with staff assistance as needed. There is consistent meal presentation with meals being served and plated by chefs/cooks in the kitchen. Project delicious focused on providing choice which has bridged the menu gap for residents of other cultures and ethnicities. The chefs do a walkaround to the units and welcome feedback from residents and family. Resident and relative survey results for February 2018 demonstrate an increase in satisfaction with meals and the meal service from 3.0 in 2017 to 4.09 in 2018. Residents and relatives interviewed were very satisfied with the meals and choice provided.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths</p>	<p>CI</p>	<p>Malvina Major village and care centre have many residents with a shared love of music appreciation. The resident-led group first</p>	<p>The care centre residents enjoy a stimulating activity programme during the day. Music appreciation (village resident-led) is an evening session that occurs weekly at 7.00pm and has been opened up to rest home and hospital residents who share the love of music appreciation. This activity has been added to the rest home and hospital activity programme. The Burma lounge has been upgraded with installation of new sound equipment such as sound loop, audio visual and TV equipment to improve the sound and acoustics of music.</p>

<p>(skills, resources, and interests) that are meaningful to the consumer.</p>		<p>started in 2005 and now has 20-30 residents attending the weekly programme. The Burma lounge has been upgraded to accommodate and provide a venue where residents and guests can engage in a functional or social manner.</p>	<p>The sound loop has improved hearing for those residents wearing hearing aids. The addition of a kitchenette allowed the group to be self-sufficient for catering and functions. The agenda has a different speaker (resident or guest speaker) each week, who chooses a piece of music, shares memories and speaks about the piece of music. Resident attendance records identify at least 50% of attendees at music appreciation are residents from the care centre. Residents have developed new skills such as the management of equipment, sound technician role and building confidence in speaking in front of others.</p>
<p>Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>CI</p>	<p>A continuous improvement project to reduce the number of complaints regarding missing clothing was commenced in December 2016. The service has been successful in reducing the amount of missing clothing.</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 was renovated to improve the workflow and space in the laundry. The laundry person interviewed on the day of audit could describe the procedure for reducing the amount of missing clothing. There were no un-named or missing clothing on the day of audit. Residents and relatives were informed of the labelling procedure. Ongoing discussions at the resident meetings (minutes sighted) and laundry audits (100%) evidenced an improvement in laundry procedures. The service has been successful in reducing the amount of un-named/missing clothing with zero complaints since the project was introduced. The resident satisfaction survey results demonstrated an increase in resident/relative satisfaction with laundry services.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations</p>	<p>CI</p>	<p>Surveillance is completed monthly for all infections that meet standard definitions. Surveillance data is made available for all</p>	<p>The service identified an improvement around reducing respiratory tract infection rates in September 2016 due to spike in respiratory infections to 4.21/1000 bed nights across the care centre. An action plan included an analysis and trending of respiratory tract infections, early reporting of signs and symptoms and isolation of residents, resident educations, staff education, wearing of masks when caring for affected residents, encourage residents to drink fluids and practice good personal hygiene and hand hygiene, encouraging staff to stay at</p>

<p>to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>staff and discussed at facility meetings. Benchmarking includes the organisational quality indicators for infections. The service has been successful in reducing respiratory tract infections below the upper limit for rest home and hospital residents.</p>	<p>home when unwell and focusing on the flu vaccine campaign for residents and staff. In 2017, 52% of staff received flu vaccines and in 2018 there were 81% of staff who received flu vaccines. In May 2017, there were 2/1000 bed nights respiratory infection rate (group average 2.5/1000 bed nights) and zero respiratory tract infections in May 2018 (group average 2/1000 bed nights). The service has been successful in reducing respiratory tract infections across the care centre.</p>
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End of the report.