

# Kiri Te Kanawa Retirement Village Limited - Kiri Te Kanawa Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Kiri Te Kanawa Retirement Village Limited
<b>Premises audited:</b>	Kiri Te Kanawa Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 26 September 2019    End date: 27 September 2019
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	97



# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Ryman Kiri Te Kanawa provides rest home, hospital and dementia level of care for up to 127 residents. There were 97 residents at the time of the audit.

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

The village manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and the services provided.

There are two areas of continuous improvement awarded around the implementation of corrective action plans and the 'Project Delicious' food service.

## 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.		Standards applicable to this service fully attained.
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Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an incident or has a change in their current health. There is an established system implemented for the management of complaints. There are very few complaints received.

## 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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant to the manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews.

A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families 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.		Standards applicable to this service fully attained.
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InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrated service integration. Residents and family interviewed confirmed they were involved in the care plan process and review and were informed of any changes in resident health status. The general practitioner completes an admission visit and reviews the residents at least three monthly.

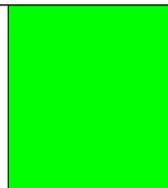
The activity team provide an activities programme which is varied and interesting. The programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups.

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

The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in the dementia care unit.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

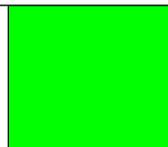


Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility.

## 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 two residents with restraint and five residents with enablers during the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs and a six-monthly comparative summary is completed. The service has had two outbreaks during 2019 which have been appropriately managed and promptly reported to public health.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	2	39	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with seven residents (four hospital and three rest home with one in a serviced apartment) and family, confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Three complaints received in 2019 (year to date) have been managed in a timely manner and are documented as resolved. One of these complaints was lodged with HDC on 15 February 2019. This complaint was referred on to HDC Advocacy services by HDC and has now been resolved.</p> <p>Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.</p>
<p>Standard 1.1.9: Communication Service providers</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. Six family interviewed (three hospital, two dementia, one rest home) stated they were well-informed. Ten incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed, for residents who are unable to speak or understand English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kiri Te Kanawa is a Ryman Healthcare retirement village located in Gisborne. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care in their care centre for up to 97 residents. In addition, there are 30 serviced apartments that are certified to provide rest home level care. In the care centre, there are 81 dual-purpose (rest home/hospital) beds and sixteen beds in the secure unit for dementia level of care.</p> <p>Occupancy in the care facility during the audit was 37 rest home, 42 hospital and 13 dementia level residents. In addition, there were five rest home level residents in the serviced apartments. There were four rest home level residents on respite. The remaining residents were on an aged residential care contract (ARCC).</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Four organisational objectives for 2019 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives. Objectives and the progress towards meeting these objectives are posted in the staff room.</p> <p>The village manager has been in his role for five years. He holds over 30 years' experience in business leadership roles and has attended over eight hours annually of professional development activities relating to managing a retirement village. The village manager is supported by a regional manager, an assistant to the manager and a clinical manager/RN. The clinical manager is a registered nurse (RN) who has been in her role at this facility for five years and has been employed with Ryman for 11 years. She has over 30 years of aged care experience.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>Ryman Kiri Te Kanawa has an 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 two managers (village manager, clinical manager); seventeen staff (four caregivers (one hospital, one rest home, one dementia, one serviced apartment); three unit coordinators (two RNs and one EN); two staff RNs; one chef, two kitchenhands, three activities staff, one maintenance, one assistant to the manager) and review of management and staff meeting minutes demonstrated their involvement in quality and risk</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>activities.</p> <p>Resident meetings are held two-monthly. Minutes are maintained. Annual resident and relative surveys are completed. Recent relative survey results for 2019 reflected Kiri Te Kanawa as being rated as number one amongst all Ryman facilities. Where opportunities for improvement are identified, quality improvement plans (QIPs) are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, as evidenced in the full facility 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. A robust internal auditing programme is being implemented. In addition, the facility has implemented processes to collect, analyse and evaluate clinical indicator data, which are utilised for service improvements. Results are communicated to staff 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. Of particular mention are recent corrective actions (quality improvement plans) that have been implemented to address meals, staff satisfaction, and falls in the dementia unit).</p> <p>Health and safety policies are implemented and monitored. A health and safety representative was interviewed. Health and safety meetings are conducted two-monthly. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings.</p> <p>The service has maintained a continuous improvement in relation to the results achieved from maintaining the rate of residents' bruising below the Ryman average/target.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of 10 incident/accident forms identified that all are fully completed and include follow-up by a registered nurse. Neurological observations are completed if there is 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</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>meetings. This provides the opportunity to review incidents as they occur.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. This included completing section 31 reports (pressure injury, police investigations) and notifying public health for two outbreaks since the previous audit.</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>Human resources policies cover recruitment, selection, orientation and staff training and development. Seven staff files reviewed (two staff RNs, four caregivers, one kitchen assistant) included a signed contract, job description relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>A register practising certificates for RNs and other health professionals is maintained within the facility to provide evidence of registration.</p> <p>There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Fourteen of sixteen registered nurses (including the clinical manager) have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Seven of ten caregivers who work in the dementia unit have completed their dementia qualification. Three are enrolled and have been employed for less than 18 months.</p> <p>There is a minimum of one staff available 24/7 with a current CPR/first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The facility covers three floors with elevators in strategic locations. The clinical manager is an experienced registered nurse with a current practising certificate who works full-time Monday – Friday.</p> <p>The ground floor (1st level) had 42 hospital and 26 rest home residents. Staffing includes a unit coordinator/RN (Tuesday – Saturday). Three staff RNs cover the AM shift (two long and one short shift to 1.30 pm) and two staff RNs cover the PM shift. The night shift is staffed with one RN. (Note: an additional RN is rostered over the two</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>days that the unit coordinator is not rostered). Eleven caregivers are rostered on the AM shift (six long and five short) and nine are rostered on the PM shift (four long and five short). The night shift is staffed with three (long shift) caregivers. One fluid assistant covers from 9.30 am-1 pm and a lounge carer assists from 4 pm – 8 pm.</p> <p>Thirteen dementia level residents were in the secure dementia unit on the 2nd level. A unit coordinator/RN covers the dementia unit (and the rest home residents on the 2nd level) from Sunday – Thursday. An RN covers on the two days that the unit coordinator is not available. The dementia unit is staffed with two caregivers on the AM and PM shifts (one long and one short) and one caregiver on the night shift.</p> <p>Eleven rest home level residents were on the 2nd level. One caregiver covers each shift.</p> <p>There are thirty serviced apartments certified to provide rest home level of care that cover two floors (2nd and 3rd levels). There were five rest home level residents in the serviced apartments at the time of the audit. The serviced apartment coordinator is an enrolled nurse (EN) with a current practising certificate and works Sunday – Thursday. An RN covers in her absence (Fridays and Saturdays). The AM and PM shifts are staffed with two caregivers. For the PM shift, one caregiver works until 7 pm and a second caregiver works until 9 pm. The PM shift after 9 pm and the night shift is covered by a caregiver in the rest home. Staff communicate via mobile telecommunications.</p> <p>Extra staff can be called on for increased resident requirements. A cover pool has been implemented whereby (extra) care staff are scheduled to work Friday – Monday to cover absences. These assigned staff (two caregivers from 7 am – 1 pm and one RN from 7 am – 3.30 pm) work regardless if staff are absent. Additional casual staff are available if needed.</p> <p>Activities staff are scheduled seven days a week in the hospital and dementia units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered seven days a week.</p> <p>Staff were visible and were attending to call bells in a timely manner as observed by the auditors and confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were two residents (one on respite care and one resident in the serviced apartments) self-administering on the day of audit. Both residents had current self-medication competencies in place. There are three medication rooms and one medication cupboard on site, one for each level of care and all have secured keypad access. Medication fridges had weekly temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored. Registered nurses, enrolled nurses and senior caregivers, who have passed their medication competency, administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The service</p>

<p>requirements and safe practice guidelines.</p>		<p>does not use standing orders.</p> <p>The facility utilises an electronic medication management system. Twelve medication profiles were sampled (four hospital, four rest home (including two from the serviced apartments) and four dementia level of care). All twelve medication charts had photo identification and allergy status documented. All charts evidenced three monthly reviews by the NP/GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of PRN medication administered were documented in the electronic prescription. Controlled drugs and registers aligned with guidelines.</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 service has a well-equipped commercial kitchen on site where all food and baking is prepared and cooked. The qualified head chef is supported by a second chef and four kitchenhands. Staff have been trained in food safety and chemical safety. The seasonal menu has been designed in consultation with the dietitian at an organisational level. "Project delicious" has been in place since opening. Menu choices are decided by residents (or family/EPOA/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. All meals are transported in hot boxes to each units' satellite kitchen, where the meals are served from bain maries. The chef receives a dietary profile for all new resident admissions and is notified of any dietary changes. Resident likes and dislikes are accommodated and listed on the daily spreadsheet and kitchen noticeboard. Alternative foods are available on the menu or offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours a day. There is a supply of snacks and fruit in the dementia unit kitchenette.</p> <p>Freezer and chiller temperatures and end-cooked temperatures are monitored and recorded twice daily. The chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained by the chef and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing. The food control plan expires on 11 January 2020.</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>The service has maintained the continuous improvement in relation to improving meal services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a nursing review and if required NP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that evidenced 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.</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Residents interviewed reported their needs were being met. Discussions with families confirmed they were 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. There were 19 wounds on the day of the audit; 12 in the hospital (two pressure injuries, seven skin tears and three chronic leg ulcers), two wounds documented in the dementia unit (one skin tear and one chronic leg ulcer), four in the rest home (one pressure injury and three chronic ulcers) and one resident with chronic leg ulcers in the serviced apartments. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for all 19 wounds. There was evidence of the wound care nurse specialist, GP, dietitian and facility wound champion involvement in the management of the complex wounds and pressure injuries.</p> <p>Continence products are available and resident files included a three-day 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 myRyman system which include weight, vital signs, behaviour monitoring and assessment, pain, neurological observations and blood glucose monitoring. The progress notes documented changes in health status and significant events.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The team of activity and lifestyle staff (two diversional therapists and four activity and lifestyle coordinators) coordinate and implement the Engage activities programme across the hospital, rest home, dementia unit and serviced apartments seven days a week. The dementia care unit diversional therapist (DT) has completed the dementia unit standards. The hospital and serviced apartments activity and lifestyle coordinators are progressing through their diversional therapy qualifications. The two DT and one activity and lifestyle coordinator that do the van trips hold current first aid certificates.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, themes events and celebrations, indoor bowls, sensory activities, baking in the kitchenettes, outings and drives. The service has a mobility van for resident outings. Rest home residents in the serviced apartments can attend the serviced apartment programme or rest home programme. One-on-one time is spent with residents who are unable to participate or choose not to be involved in the activity programme. Special events and theme days are celebrated. Village friends visit and participate in some activities. Residents use the on-site movie theatre for regular movie nights and are currently following the Rugby World Cup games. Community involvement includes entertainers, speakers, and church services. The activities staff have been successful in engaging residents in the Engage programme especially around the pampering sessions and men's club as evidenced in the residents' survey results. The dementia care unit residents have access to a secured outdoor garden setting, with shaded seating and raised gardens. This</p>

		<p>space is used for walks, gardening activities and resident/family barbeques.</p> <p>The residents have an activity assessment that is completed on admission. The activity plan in all resident files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for the five long-term residents were evaluated by the RN within three weeks of admission. One of the five long-term resident files demonstrated that the interRAI assessments and care plans reviewed were evaluated at least six monthly or when changes to care occurred. The other four residents (two hospital and two dementia level of care) were not in the service for six months. Extended sampling on three long-term rest home resident files verified that long-term care plans were evaluated six-monthly by the registered nurses. The respite resident had a short-term care plan in place. Written evaluations identified if the resident/relative desired goals had been met or unmet. All changes in health status were documented and followed up. The multidisciplinary review involves the unit coordinator, RN, activities staff and resident/family member. The six resident files reviewed reflected evidence of family being involved in the planning of care and reviews and if unable to attend, they receive a copy of the reviewed plans. In all six files reviewed the care plans had been read and signed by the resident/EPOA/family. There is at least a three-monthly review by the medical practitioner with majority of the hospital level residents being seen monthly. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and NP/GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a warrant of fitness that expires 1 July 2020. The facility employs a full-time maintenance person who is supported by part time maintenance staff and gardening staff. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule. Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration have been completed. Hot water temperatures in resident areas are monitored three-monthly. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade are provided.</p> <p>The dementia unit on the second floor has a secure and safe outdoor balcony deck with raised gardens, seating and shade.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p>

<p><b>Standard 3.5: Surveillance</b></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>FA</p>	<p>Definitions of infections are appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (registered nurse) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes included identifying trends, corrective actions and evaluations and are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>The service has had two outbreaks in 2019 (norovirus in April and influenza in May). Relevant authorities including public health were notified, and documentation was completed on a daily basis. Staff were kept informed at handovers and by daily memos and emails. All staff received educational training and debrief. Infection control policy and practice meets best practice.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></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 two hospital residents with restraint (chair briefs) and five hospital residents who had requested enablers (lap safety belt, bedrails). One file of a resident using an enabler was reviewed that reflected an enabler assessment, six monthly voluntary consent by the resident and six-monthly reviews of the use of the enabler. The enabler usage was linked to the resident's care plan.</p> <p>Staff training is provided six-monthly around restraint minimisation and managing of challenging behaviours. Staff interviews confirmed their clear understanding of the difference between an enabler and a restraint.</p>

## Specific results for criterion where corrective actions are required

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

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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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. The rate of bruising is consistently below the Ryman target and results in a rating of continuous improvement.</p>	<p>Data collated is used to identify any areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Corrective action plans reviewed reflected significant improvements (eg, satisfaction with food, reducing falls in the dementia unit, addressing staff satisfaction). Of particular note is the rate of residents' bruising per 1000 bed nights, which has been significantly below the Ryman average for 2019. Strategies implemented have included mandatory manual handling courses for staff every six months and competency assessments led by the physiotherapist and unit coordinator to ensure that staff are implementing what they have learned in the training. This previous area identified as a continuous improvement remains.</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>The service has implemented a Ryman initiative called “Project Delicious” to better meet the resident’s dietary preferences and dislikes by providing three options of meals at the midday and evening meal. Feedback from resident and relative interviews confirmed a continued increase in meal satisfaction and choice. Survey results showed an increase in resident satisfaction in meals.</p>	<p>The September 2016 continuous improvement quality action plan (“Project Delicious”) has continued to be implemented. Strategies including (but not limited to) the Ryman menu: the main meal offering three main meal choices including two meat options and a vegetarian option and the evening meal also provides options for meat or vegetarian foods remain. Staff assist residents to complete their menu plan in advance. The menu options continue to accommodate resident dietary requirements/preferences and dislikes and residents can request food outside the menu plan. The main meals in the rest home and the hospital units continue to be served by the head and assistant chef. All new staff have received training on meal presentation, serving and table setting. Fine dining events are enjoyed by residents and families alike. Resident survey results for meal satisfaction reflected a further increase from 3.56 (February 2018) to 3.87 (February 2019).</p>
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End of the report.