

# Julia Wallace Retirement Village Limited - Julia Wallace 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>	Julia Wallace Retirement Village Limited
<b>Premises audited:</b>	Julia Wallace Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 17 February 2020      End date: 18 February 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	81



# 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 Julia Wallace provides rest home, hospital and dementia level of care for up to 104 residents. There were 81 residents at the time of the audit.

This unannounced surveillance audit was conducted against a subset of the 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, family, management and staff.

The facility manager has significant health management experience and works full time. She has been in the position for seven years. She is supported by a clinical manager.

The service has an established quality and risk management system. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The previous audit did not identify any shortfalls. This audit identified two areas for improvement; around neurological observations and hot water monitoring.

## 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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (The Code). Residents and family interviewed verified that resident rights are respected and the communication with the service is very good.

## Organisational management

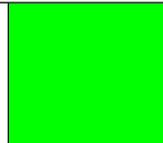
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a business plan with goals for the service that has been regularly reviewed. Julia Wallace has fully implemented the Ryman quality and risk system. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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.

The registered nurses' complete assessments, care plans and evaluations using an electronic system. Residents/relatives are involved in planning and evaluating care. Risk assessment tools including the interRAI assessment tool, and monitoring forms are included on this system and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated.

The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff complete competency assessments.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably regarding 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.		Some standards applicable to this service partially attained and of low risk.
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The building holds a current warrant of fitness that expires on 19 December 2020. There is a reactive and planned maintenance plan schedule in place.

## 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.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint and four residents with enablers during the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## 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	14	0	2	0	0	0
<b>Criteria</b>	0	40	0	2	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 visible locations around the facility. Information about complaints is provided on admission. Interviews with all residents (three rest home and two hospital level) and family confirmed their understanding of the complaints process. They reported that they would feel comfortable addressing a concern with the village manager and/or clinical manager. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system.</p> <p>Fourteen complaints were logged for 2019; all complaints included an acknowledgment, investigation and responses to the complainant within timeframes. Eight complaints were around theft. The service has investigated the issue very comprehensively, including involving the police and the use of security cameras. This issue has now been resolved. Staff and families were kept informed regarding the process through memos, meetings and one on one conversations. There were two complaints through the Health and Disability Commissioner, both of which have been closed to the satisfaction of the Commissioner.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. The village manager and clinical manager confirmed family are kept informed. Relatives (two hospital, two rest home and two with family members in the secure dementia unit) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>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 information pack is available in large print and in other languages.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Julia Wallace is a Ryman Healthcare retirement village located in Palmerston North. They are certified to provide rest home, hospital and dementia levels of care in their care centre for up to 81 residents. There are also 20 serviced apartments that are certified to provide rest home level care. Sixty-three beds in the care centre are certified as dual purpose beds and twenty-one beds are available in the special care unit for dementia level of care.</p> <p>Occupancy in the care centre was 27 rest home, including one ACC and one respite; 31 residents at hospital level including one funded through the Long-Term Support-Chronic Health Conditions contract (LTS – CHC) and 21 dementia level residents. There were two rest home level residents in the serviced apartments. The hospital level of care is certified for geriatric and medical services.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Annual objectives are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives. Staff are kept informed of progress in the full facility meetings.</p> <p>The village manager has been in her role at this facility for seven years. She trained as a medical technologist. The village manager is supported by a regional manager, an assistant manager and a clinical manager/RN. She has attended a minimum of eight hours of professional development per year relating to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>Ryman Julia Wallace continues to implement the 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 staff (six caregivers, one head chef, one maintenance person, eight registered nurses and an activity staff member), and review of management and</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident and relative meetings are held, including separate meetings for the dementia unit relatives. Minutes are maintained with evidence of follow-up. Examples include; additional fruit available to the residents in the lounges and gravy served in individual jugs. Annual resident and relative surveys are completed with the last survey completed in August 2019, noting an improvement in food services from the previous year. Results are benchmarked against all Ryman facilities.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team meetings. 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. The service develops quality improvement plans where internal processes such as incident, infection control internal audit document an adverse result. QIPs are documented as followed up, reported to meeting and resolved. QIPs have included action plans for; theft, medication audits, an increase in pressure injuries, wound care, care planning and falls as examples. Quality initiatives commenced include; integration of care centre residents and village people, improvements to the 'moulied' diets and a project to research links and collations between better nutrition and pressure injuries.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and identify trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Health and safety policies are implemented and monitored. Two health and safety officers were interviewed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>PA Low</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 ten incidents and accidents for January 2020 identified that all forms were fully completed and include follow up by a registered nurse, however neurological observations were not always completed</p>

<p>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>according to Ryman policy. 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.</p> <p>Six monthly reviews of incidents and accidents are documented. The review includes trends, review of most common reasons for falls, location, frequent fallers and serious falls (such as fractures). The reports are communicated to head office and to the service meeting, subsequent action plans are documented as followed up. Pressure injuries, behaviours that challenge, also have a similar six-monthly review documented.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities with examples provided. There have been four section 31 notifications; these were for pressure injuries (two facility acquired and two non-facility acquired).</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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (two-unit coordinators, two staff RNs, one diversional therapist, one housekeeper and three caregivers) included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in and completed induction checklists. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Training is provided through a variety of forums including, staff and service meetings, journal club, in-service training sessions and Skype.</p> <p>Registered nurses are supported to maintain their professional competency. Journal club meetings are provided two-monthly. Twelve of fourteen registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Eighteen of twenty-five caregivers who work in the dementia unit have completed their dementia qualification. The remaining seven caregivers have been employed for less than one year in the dementia unit and are in the process of completing their qualification.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The clinical manager is an experienced registered nurse with a current practising certificate who works full time Tuesday-Saturday. She is supported by four-unit coordinators (three RNs in rest home, dementia, hospital and one enrolled nurse in serviced apartments) who provide cover over seven days between them.</p> <p>The facility covers two floors with an elevator and stairs for access. There are twenty serviced apartments certified to provide rest home level of care that span two floors, with two rest home level residents during the audit. The serviced apartment unit coordinator (EN) or a senior caregiver cover seven days a week and are supported by a caregiver on the AM shift and also on the PM shift. The rest home caregivers cover the serviced apartments after 9 pm and through the night shift. Staff communicate via mobile telecommunications.</p> <p>The care facility is located on the ground floor. Staffing includes a hospital unit coordinator/RN (Sunday - Thursday) and a rest home unit coordinator/RN (Tuesday - Saturday). This is in addition to two staff RNs who are assigned to cover hospital level residents on the AM and PM shifts.</p> <p>The night shift is staffed with one RN and six caregivers for the service.</p> <p>Hospital caregiver staffing for 31 residents includes:</p> <p>AM; seven caregivers. PM; five caregivers plus a lounge assist person (short shift).</p> <p>Rest home caregiver staffing for 27 residents includes:</p> <p>AM; three caregivers. PM two caregivers.</p> <p>Secure dementia unit (21 beds, currently 21 residents). The dementia unit is staffed with a unit coordinator (RN) from Tuesday – Saturday and an RN on Sunday and Monday. There are two caregivers who work the AM shift (long shifts), and three caregivers who cover the PM shift (two long and one short shift). Two caregivers cover the night shift.</p> <p>Activities staff are scheduled seven days a week in the hospital and dementia units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p>
<p>Standard 1.3.12: Medicine</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</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>packs is completed by RNs and the medication competent senior carers and the back of the blister pack is signed and dated. Any errors are fed back to the pharmacy. Registered nurses, enrolled nurses and medication competent 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 twice daily. Medication room temperatures are monitored.</p> <p>All eye drops and creams in medication trolleys were dated on opening. There are regular checks of all medication expiry dates and oxygen cylinders. There was one resident self-medicating on the day of audit; this resident had a medication competency on file and their medication is kept securely locked.</p> <p>Twelve medication charts were reviewed. All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. 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.</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>	FA	<p>There is a head chef, second chef, kitchenhands and kitchen assistants. Staff have been trained in food safety. The service has a food control plan that expires 29 July 2020. 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. Meals are served and/or plated in the kitchen and delivered in hot boxes to each satellite kitchen. 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 reheating temperatures are taken and recorded as sighted. All foods were date labelled and checked for expiry dates regularly. A cleaning schedule is maintained for the cook and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents provide feedback on the meals through resident meetings, resident survey and direct contact with the chef. Residents and relatives interviewed spoke positively about the choices and meals provided.</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</p>	FA	<p>When a resident's condition alters, the registered nurse initiates a nursing review and if required, NP, GP, or 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 of any changes to their relative's health.</p> <p>Registered nurses stated that there are adequate dressing supplies. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place</p>

<p>desired outcomes.</p>		<p>for residents with wounds and recorded on the electronic system.</p> <p>There were fifteen skin tears, one abrasion, five 'other' wounds, two ulcers, eight lesions and one sinus being treated on the day of the audit.</p> <p>One resident had a stage one and stage two pressure injury (they were admitted with these injuries). One resident had two stage three hospital acquired pressure injuries; one resident had one stage three hospital acquired pressure injury; and one resident had a stage four pressure injury that was facility acquired (and had been classified as a stage four by the vascular surgeon). A Section 31 had been completed for each of these pressure injuries. The facility has an RN/wound champion who reviews wounds as required. Clinical records demonstrated input by the wound nurse specialist, dietitian, physiotherapist, nurse practitioner and GP as required. Each resident at risk of pressure injuries has pressure injury prevention strategies in place.</p> <p>The clinical manager had implemented a quality improvement plan for pressure injury prevention that included ensuring all residents with changes in mobility or declining health have comprehensive assessment tools in place to monitor changes to skin integrity; and ensuring all residents that return from hospital have a comprehensive skin check in place on their return; and the monitoring of incidents; and maintaining good skin integrity with daily moisturising of residents skin.</p> <p>Staff have undertaken online dementia care training to enhance their knowledge of identifying triggers and working with families more closely to develop an understanding of residents' backgrounds so effective activities and behaviour management strategies can be identified.</p> <p>Continence products are available and resident files included 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>Monitoring forms available on the electronic system include weight, vital signs, behaviour monitoring and assessment, pain, neurological observations and blood glucose monitoring.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>FA</p>	<p>There is an activities team that includes activities and lifestyle coordinators for the rest home, hospital and dementia care sections. There are four other activities team members who also provide activities across the service. There are activities provided seven days per week.</p> <p>The Engage programme has an activities calendar that is relevant for the resident group including (but not limited to); Triple A exercises, news and views, baking, happy hour, memory lane, 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>needs, age, culture, and the setting of the service.</p>		<p>Community visitors include entertainers, church visitors, pre-school children, and canine friends. There are weekly outings and scenic drives for rest home, hospital and dementia care residents. A van is used for rest home and dementia residents. The rest home residents have a drive to nearby areas and café visits. The dementia care residents have enjoyed sightseeing the new murals in town, visiting the countryside and reminiscing about places they would visit in their past. A mobility taxi is used for outings for hospital residents, they visit cafés and other community activities.</p> <p>Music includes entertainers and musical moments.</p> <p>Resident life experiences and activity assessments are completed for residents on admission. The activity plans 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>	<p>FA</p>	<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. Residents and family confirmed their participation in care plan evaluations. The nurse practitioner and general practitioner reviews the residents at least three monthly or earlier as required. Regular NP and/or GP reviews occurred as sighted in current NP/GP progress reports.</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>PA Low</p>	<p>The facility has a current building warrant of fitness that expires on 19 December 2020. The maintenance manager was interviewed and described that hot water monitoring was completed but actual records were not retained (records were unable to be sighted) as a part of the reactive and preventive maintenance system. The facility has access to maintenance personnel after hours as required. The maintenance management system is electronic. There are well kept garden areas with accessible outdoor spaces, seating and shade including a secure area for those in the dementia unit.</p>
<p>Standard 3.5:</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are</p>

<p>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>completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control coordinator completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There was a respiratory infection outbreak January 2020. Public Health was notified and documentation demonstrated the outbreak was well-managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint and four using bed rail enablers.</p> <p>Two resident files were reviewed for the use an enabler and reflected an assessment, voluntary consent process (gained from the resident) and regular (six-monthly) reviews.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Incident forms are completed for all incidents, ten resident related incidents all documented RN follow up. Resident follow-up included intentional rounding, pain reviews, falls reassessments and care interventions. Progress notes documented ongoing resident checks and care. Three incidents required neurological observations, all three had been commenced but not continued according to Ryman timeframes.	Three fall related incident forms that required neurological observation did not have the observations documented as per policy.	<p>Ensure that neurological observations are completed according to set policy.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	The facility has a current building warrant of fitness. Reactive and preventive maintenance is in place. Records described hot water monitoring being completed, however actual records for these hot water temperatures were unable to be sighted. The facility has access to maintenance personnel after hours as required. The maintenance management system is electronic.	Hot water monitoring documents that temperatures are monitored and within an acceptable range, but the temperature records were not retained and unable to	Ensure hot water temperature monitoring is recorded and records retained to demonstrate the water temperatures are within an

			be sighted.	acceptable range. 90 days
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.