

Diana Isaac Retirement Village Limited - Diana Isaac Retirement Village

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:

Legal entity:	Diana Isaac Retirement Village Limited
Premises audited:	Diana Isaac Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 11 June 2018 End date: 12 June 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:	118



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

Diana Isaac is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital (geriatric and medical) and dementia care level care for up to 160 residents (120 care centre and 40 certified serviced apartments). On the days of the audit there were 118 residents including three residents receiving rest home level of care in serviced apartments. The service is managed by a village manager who is supported by two clinical managers. The residents and relatives interviewed spoke positively about the care and support provided.

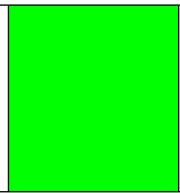
This surveillance audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives,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

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Ryman quality and risk management programme that is individualised to Diana Isaac. Quality initiatives continue to be implemented which provide evidence of improved services for residents.

The one shortfall from the previous audit around interRAI assessments has been addressed. This audit did not identify any areas requiring improvement.


The service is commended for achieving continuous improvement ratings around reduction of falls, 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.		Standards applicable to this service fully attained.
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Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Relative meetings for each unit is held regularly. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

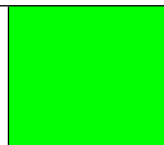
Organisational management

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 and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The quality and 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. An orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments. Registered nursing cover is provided seven days a week. Residents and families report 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.

InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses within the required timeframes. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission and visits and reviews the residents at least three monthly.

The activity team provides an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The engage programme meets the abilities and recreational needs of the groups of residents. There are 24-hour activity plans for residents in the dementia care unit.

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 general practitioner reviews medications three monthly.

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. Preventative and reactive maintenance occurs as required.

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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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with enablers and four residents with restraint at the time of the audit. Staff receive training around restraint minimisation and enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Policies and procedures reflect best practice including definitions for surveillance. Monthly infection events are collated and forwarded to head office for analysis and organisational benchmarking. The results of surveillance are used to identify infection control quality initiatives and education requirements.

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	0	17	0	0	0	0	0
Criteria	2	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at Diana Isaac facility. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and operations manager are involved in clinical complaints. The facility has an up-to-date complaint register for each unit. Concerns and complaints are discussed at relevant meetings. There have been six complaints made in 2017 and one complaint received in 2018 year-to-date. There was documented evidence of internal investigations and family meetings with resolution for all complaints. Complaints have been acknowledged and addressed within the required timeframes. One of the complaints in 2017 was made through the DHB and the service completed internal investigations with no further action required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Fifteen incident forms reviewed evidenced the family had been informed of the accident/incident. Seven relatives (three rest home, two hospital and two dementia care) interviewed, stated that they are informed when their family members health status changes. Six monthly relative meetings occur in each of the units (rest home, hospital and dementia care). The village manager provides a village report for all families that includes facility matters and survey results. Seven residents (five rest home including one in the serviced apartments and two hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia</p>

<p>conducive to effective communication.</p>		<p>unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.</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>Diana Isaac Retirement Village is a Ryman Healthcare facility, situated in Christchurch. The service currently provides care for up to 120 residents at hospital, rest home and dementia level care in the care centre and up to 40 rest home level of care residents in the serviced apartments. The facility is across three levels. At the time of the audit there were 118 residents in total, 39 rest home residents in the 40-bed rest home unit (all dual-purpose beds), 37 hospital residents including one resident on respite care in the 40-bed hospital unit (all dual-purpose beds) and 39 dementia care residents (across two 20-bed dementia units). At the time of the audit there were three rest home residents in the serviced apartments. All residents were under the aged related residential care (ARRC) agreement.</p> <p>Ryman Healthcare has an organisational business and quality management plan. Quality objectives and quality initiatives are set and reviewed annually. The village quality objectives and quality initiatives for 2017 have been reviewed with achievements around implementation of a cover pool of staff for unplanned absences, introduction of a training squad to orientate staff to facility and work areas and election of health and safety committee members representative of each area. The village objectives for 2018 have been discussed at full facility meetings.</p> <p>The village manager at Diana Isaac is non-clinical and has been at Ryman for 11 years and in this role for the last two months. She was previously in a regional manager role for a year. The village manager has completed a comprehensive orientation to the role and has attended a two-day manager training day. The village manager is supported by a clinical manager. The village manager and clinical managers are supported by a part time clinical leader, three unit-coordinators/RN, rest home, hospital and dementia units and one unit-coordinator/enrolled nurse (EN), serviced apartments. The management team is supported by the Ryman management team including a regional manager and clinical practice and audit manager.</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>Diana Isaac has a well-established quality and risk management programme that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings (team Ryman, full facility, clinical, health and safety infection control meetings) and reported to the organisation's management team. Discussions with the management team (village manager, assistant manager and clinical manager) and staff, and review of meeting minutes demonstrate their involvement in quality and risk activities. Resident meetings are held two-monthly in each area and family meetings are held six-monthly. Annual resident and relative surveys are completed. Results and any areas for improvement are fed back to staff and participants through meetings and village reports to relatives. At the time of the audit the results for the 2018 resident and relative satisfaction surveys</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>had not been completed.</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. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the combined monthly health and safety and infection control meetings. The health and safety officer (activities coordinator) was interviewed. She has completed level four external health and safety training. Health and safety meetings are conducted bi-monthly. Risk management, hazard control and emergency policies and procedures are in place. 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 hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register, and the maintenance register indicate that there is resolution of issues identified. 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 triple A exercise programme. The service has achieved a continuous improvement in relation to falls reduction.</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</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 15 incident/accident forms from across all areas of the service, identified they all were fully completed, including follow-up by a RN and relative notification. Post falls assessments included neurological observations for any unwitnessed falls. The clinical manager is involved in the adverse event process, with links to the applicable meetings (team Ryman, full facility, clinical, health and safety/infection control). 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. There has been a section 31 for a previous stage three pressure injury and a notification to public health for a norovirus outbreak in November 2017.</p>

of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (one clinical manager, two unit coordinators, two RNs, four caregivers, one head chef and one diversional therapist) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RNs, EN and health professional practising certificates are maintained and current. An orientation/induction 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. The assistant manager maintains education attendance training records. Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session. Additional toolbox sessions are provided. There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate. Registered nurses are supported to maintain their professional competency. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. There are currently 22 RNs (including the two clinical managers) working at Diana Isaac, eight RNs including the clinical managers are interRAI trained.</p> <p>Twenty-five caregivers work in the dementia unit. Eighteen of twenty-five caregivers have completed their dementia standards. There are seven caregivers in the process of completing their dementia standards. All seven caregivers have commenced work within the last 12 months.</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>	FA	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. There is a pool of casual staff to cover unplanned absences. The village manager and clinical manager work full time Monday to Friday and are on call 24/7. They are supported by a part-time clinical manager, three unit coordinators/RN, rest home, hospital and dementia units and one unit coordinator/enrolled nurse (EN), serviced apartments. Interviews with five caregivers (one hospital, one rest home, two dementia care and one serviced apartments) stated the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs.</p> <p>Staffing at Diana Isaac is as follows; i</p> <p>In the hospital there are 37 of 40 residents, there is a unit coordinator/RN who is supported by two RNs on duty on the morning and afternoon shifts, and one RN on night shift. There are eight caregivers (four full and four short-shifts) and fluids assistant on morning shift, six caregivers (three full and three short-shifts) and a lounge carer on afternoons and three caregivers on night shift.</p>

		<p>In the rest home unit there are 39 of 40 residents, there is a unit coordinator/RN who is supported by an RN on duty on the morning shift. There are four caregivers (two full and two short-shifts), five caregivers (three full and two short-shifts) and two caregivers on night shift.</p> <p>In the dementia care units, where there are currently 39 residents (across two units), there is a unit coordinator/RN who is supported by an RN on duty on the morning and afternoon shifts. There are five caregivers (three full and two short-shifts), five caregivers (two full and three short-shifts) and three caregivers on night shift. The hospital RN covers the rest home unit on the afternoon and night shifts and the dementia unit on the night shift.</p> <p>In the serviced apartments there are three rest home level residents, there is a unit coordinator/EN on the morning shift Tuesday to Saturday and a senior caregiver on Sunday and Monday. There are three caregivers on the morning shift and two caregivers on the afternoon shift. The caregivers and night RN cover the serviced apartments on night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. The service uses an electronic medication system. Medication reconciliation is completed by an RN on delivery of medication and any errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior care staff that administer medications, have been assessed for competency on an annual basis. Qualified nurses and care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly.</p> <p>Standing orders are not used. Two self-medicating residents in the rest home had been assessed and reviewed three monthly by the GP and RN as competent to self-administer.</p> <p>Fourteen medication charts were reviewed on the electronic medication system. All demonstrated that administered medications correlate with prescribed medications, all had been reviewed by the GP three monthly and all 'as required' medication had an indication for use and the effectiveness of the medication documented.</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</p>	<p>FA</p>	<p>The service employs a qualified head chef who is supported by a chef assistant, cooks and kitchen assistants. All staff have been trained in food safety and chemical safety. There is a four-weekly seasonal menu that had been designed in consultation with company chefs and the dietitian at organisational level. All meals are prepared and cooked on-site. The Ryman Food Control Plan was verified in December 2016.</p> <p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are known. Alternative foods are offered. The menu includes a second evening meal option and a chef's choice fortnightly. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft and diabetic</p>

<p>service is a component of service delivery.</p>		<p>desserts are provided. Residents that can, are provided with the following weeks menu and make meal choices off the menu for the following week. Food is delivered in scan boxes and served from bain maries in each of the unit kitchenettes. "Food on the run" finger foods are delivered to the dementia care units daily and as required. Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits.</p> <p>Residents and family members spoke positively about the 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 desired outcomes.</p>	<p>FA</p>	<p>Residents and relatives interviewed reported their needs were being met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Resident care plans are updated to reflect changes in care. The respite resident had initial assessments and a basic care plan that addressed all identified needs.</p> <p>Wound assessments, treatment and evaluations were in place for all 16 current wounds including one stage 1 pressure injury (hospital level) which was being treated as a wound to ensure monitoring. Adequate dressing supplies were sighted in the treatment rooms. Wound care advice and support can be sought from the district nursing service or wound product representative as required. The resident with the stage 1 pressure injury had their care plan updated to reflect care needs related to this and the turning chart evidenced regular position changes are occurring.</p> <p>Continence products are available and resident files include a three day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly (or more frequent) weight, blood pressure and pulse, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels, two hourly position charts and behaviour charts.</p> <p>Staff were observed to have developed a supportive relationship with the residents in the dementia unit and residents appeared to be comfortable and relaxed in their environment.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>There is a team of activity coordinators who implement separate activity programmes for the rest home, hospital and dementia units. The Ryman 'Engage' programme is currently delivered Monday to Friday in the rest home and hospital area. There are two activity coordinators in the dementia care units (one for each unit) seven days a week 9.30 am to 6.00 pm. All activity team members have a current first aid certificate. There is a separate programme for serviced apartment residents that operates Monday to Friday by a full-time activities coordinator. Rest home level residents in the serviced apartments can choose to attend the rest home activities or the serviced apartment</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>activities.</p> <p>Diana Isaac continues to implement the Engage programme. There are set Ryman activities with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Activities were observed to be delivered simultaneously in the rest home, hospital and dementia units. Residents in the dementia care unit were observed to join in a spontaneous sing-a-long. Lounge carers work 25 hours per week to provide one-on-one activities. Volunteers are involved in activities such as art and crafts, board games and bowls. There has been an increase in attendance at Engage activities particularly in the hospital and dementia care units for which the service has been awarded a continuous improvement.</p> <p>There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events. Residents are encouraged to maintain former links with community groups. Wheelchair access vans are hired for special community outings.</p> <p>Activity assessments are completed for residents on admission. The activity plans are incorporated into the myRyman on line profile and in electronic 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 and review of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident/relative meetings and satisfaction surveys. Residents and relatives interviewed voiced satisfaction with the activities provided.</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>myRyman plans reviewed across the three areas for residents that had been at the service for more than six months (one resident was on respite care and two had not been at the service for six months), had been evaluated by registered nurses' six monthly or when changes to care occurred. Written evaluations are undertaken in the form of a full new set of myRyman assessments and a new interRAI assessment, and the plan is updated to reflect any change. The multidisciplinary team review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly medical review by the GP. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 August 2018. Preventative maintenance is scheduled and implemented. Reactive maintenance is carried out as required. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade is provided.</p>

facilities that are fit for their purpose.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster management procedures and contingency plans available for staff, residents and visitors in the event of specific emergencies, including; earthquake, Tsunami, flooding, fire and unauthorised entry. Five caregivers interviewed stated that they were aware of the emergency procedures and how to implement them.</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>	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on a register and the infection prevention and control officer 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. 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>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit there were no residents with enablers and there were four residents with restraint in use (two bedrails and two lapbelts). Staff training has been provided around restraint minimisation and enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Robust systems are in place for the collection, analyses, and evaluations of quality data. A range of data is collected around falls, skin tears, pressure injuries, and infections across the service through myRyman. 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. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (eg, management, full facility and clinical/RN meetings). Templates for all meetings document action required, timeframe, and the status of the actions.	Falls were identified in the hospital unit as an area that required improvement from data collected from 2016. A continuous improvement plan was developed in January 2017 to maintain falls below the upper limit range of 11 per 1000 bed nights. The plan included identifying residents at risk of falling, reviewing call bell response times, routine checks of all residents specific to each resident’s needs (intentional rounding), reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the triple A exercise programme, reviewing of clinical indicator data in myRyman and proactive and early GP involvement. The plan has been reviewed monthly and discussed at management, staff and clinical meetings. Education and training for staff has been provided in 2017 and for new staff as part of orientation. Caregivers interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The outcome of the plan has been that falls rates for 2016 were at 13.4 per 1000 bed nights, the service reduced and maintained the falls within the hospital unit within the 2017 period

			to 11 per 1000 occupied bed nights.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Infections are included on a register and the infection prevention and control officer 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. Infections are benchmarked across Ryman and quality action plans are identified where infections are above the benchmark.</p>	<p>The IC team at Diana Isaac have continued the goal to keep UTIs below the KPI. The December 2016 continuous improvement quality action plan has continued to be implemented and evaluated with changes made to the plan when required. Strategies continue to be implemented including (but not limited to): specific tasks for the fluid assistant, training for staff, handover reminders and liaising with the GP to review interventions and medications of those residents with recurrent UTIs. Ongoing review of this action plan since December 2016 included an analysis and review/effectiveness of strategies through the clinical meetings and full facility meetings monthly. The evaluation identified that there have only been two spikes in UTIs – July 2017 and October 2017. Review identified that these were due to staff still actively using urine dipsticks and a number of residents had a significant ADL decline. Aside from these spikes UTIs have been maintained at a low rate in the dementia unit with a zero UTI rate in March and May 2018.</p>

End of the report.