

Hilda Ross Retirement Village Limited - Hilda Ross Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Hilda Ross Retirement Village Limited
Premises audited:	Hilda Ross 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: 7 March 2018 End date: 8 March 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:	146



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ryman Hilda Ross provides care for up to 171 residents across three service levels (rest home, dementia and hospital-geriatric and medical), including the provision of rest home level care across 20 certified apartments. On the day of audit, there were a total of 146 residents including two rest home level of care residents in the serviced apartments.

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

The village manager has been involved with Ryman for many years including a role as regional manager before returning to Hilda Ross as a village manager. She is supported by a deputy manager, an assistant to the manager and an experienced clinical manager. The management team are supported by a regional manager.

Residents and relatives interviewed commented very positively on the care and the services provided at Hilda Ross.

The service is commended for achieving continuous improvement ratings around activities and food services.

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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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established and implemented Māori health plan in place. Individual care plans reflect the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an adverse event or has a change in their health condition. Families and friends are able to visit residents at times that meet their needs. There is an established system that is being implemented for the management of complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, deputy 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 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 report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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There is comprehensive information available. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six-monthly. The resident/family/whānau interviewed confirmed they are involved in the care plan process and review. The general practitioner reviews residents at least three monthly.

The activity officers designated to provide an activities programme in each unit ensure the abilities and recreational needs of the residents is varied, interesting and involves the families and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs.

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. There are three-monthly GP medication reviews.

Meals are prepared on-site. The menu is designed by a dietitian at organisational level. The menu provides choice and variety. Individual and special dietary needs are catered for. 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. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme and six-monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on-site at all times. Housekeeping staff maintain a clean and tidy environment.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		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 13 residents with 14 restraints and one resident with an enabler 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. The infection control officer is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information related to the Code is made available to residents and their families. Twenty care staff, (five registered nurses (RNs), two enrolled nurses (EN), nine caregivers and four activities coordinators) interviewed, confirmed their understanding of the Code and how it is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. Specific consents were viewed for wound photographs and influenza vaccines. Written consents were sighted as part of the 13 resident file reviews (five hospital including one resident in a dual-purpose bed and one resident under PAC funding, four rest home including one resident in a serviced apartment and one resident in a dual-purpose bed and four dementia care residents including one under 65 years of age).</p> <p>Advance directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when</p>

		delivering care. Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	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 all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Eleven complaints (three rest home, six hospital and two dementia) have been received since the last audit. All complaints have been managed in a timely manner and are documented as resolved.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Six relatives (one rest home, three hospital and two dementia) and seven residents (six rest home and one hospital) interviewed, confirmed that they have been provided with information on the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager, deputy manager and clinical manager reported having an open-door policy and described the process around discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the

		scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being done. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers (across all three service areas) interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect, last occurring in November 2017.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. A Māori advocate available for any cultural support at Hilda Ross. The Maori advocate has reviewed and continues to review appropriate policies surrounding cultural competencies and Treaty awareness. She also facilitates a Cultural Awareness in-service at Hilda Ross in addition to their inhouse Cultural Awareness in-service which has been held at our Full Facility meeting – as per teamRyman directive. The Links are established with local Iwi and other community representative groups as requested by the resident/family. Family/whānau involvement in assessment and care planning and visiting is encouraged. There were no residents who identified as Māori at the time of the audit.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered, and that staff take into account their cultural values.
Standard 1.1.7: Discrimination	FA	Staff job descriptions include responsibilities. The full facility meetings occur monthly and include

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data are collected against each service level, and reported through to Ryman Christchurch (head office) for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch.</p> <p>The system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to practice, based on the evidence provided. Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the district health board which includes visits from specialists. Physiotherapists are available nine hours per week with additional support provided by a physiotherapy assistant. There is a robust education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and annual competency assessments that monitor staff comprehension for a range of topics. The RNs also participate in the RN Journal Club which is used to advise current practice and provide clinical updates and guidance.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service 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. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Regular contact is maintained with family including if an incident or care/health issues arises. All family interviewed stated they were well-informed. Twenty incident/accidents reviewed indicated that the next of kin are routinely contacted following an adverse event. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed for residents who are unable to speak or</p>

		understand English.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Hilda Ross is a Ryman healthcare retirement village located in Hamilton. They are certified to provide rest home, hospital and dementia levels of care for up to 151 residents in the care centre. In addition, there are 20 serviced apartments certified to provide rest home level care. Occupancy during the audit was 146 residents in total, 61 rest home including two rest home level residents in the serviced apartments, 51 hospital, and 34 residents receiving care across the two dementia units. Other than residents on the aged related residential care (ARRC) contract, the following contract was in place for three residents (hospital) on the DHB post-acute convalescent care (PAC) contract. There was one younger person under the age of 65 (dementia care) on the ARC contract.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2018 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been employed by Ryman for 15 years. She has been in her current role for two years and previous to this role was a regional manager for two years. The village manager is supported by a regional manager, deputy manager, assistant manager, a clinical manager and a team of four unit coordinators (one hospital/RN, one dementia/RN, one rest home/RN and one serviced apartment/EN).</p> <p>The village manager has attended over eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The deputy manager with the assistance of the clinical manager are responsible during the temporary absence of the village manager, with support provided from the regional manager.</p>
<p>Standard 1.2.3: Quality And Risk</p>	FA	<p>Hilda Ross has an established quality and risk management system that is directed by Ryman</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Annual resident and relative surveys are completed. Survey results are discussed at facility meetings. Quality improvement plans (QIPs) are completed where suggestions are identified with evidence sighted to support that residents and family concerns are addressed. 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.</p> <p>Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes. 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 facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and displayed in the staff room. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (caregiver) was interviewed. She has completed external health and safety training. Health and safety meetings are conducted 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 data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC workplace safety management practice (WSMP), expiry 31 March 2018.</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. Twenty incidents/accidents forms reviewed for February 2017, identified that all are fully completed and include follow-up by a RN. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur. Neurological observations are completed if there is a suspected injury to the head. The village manager was able to identify situations that would be reported to statutory authorities. A section 31 notification report was sighted for a stage three</p>

of choice in an open manner.		pressure injury in September 2017 that has now healed.
<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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (one clinical manager, three unit coordinators, two RNs, five caregivers, one maintenance person, one head chef and one activities coordinator) 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. A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information for safe work practice.</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. Registered nurses are supported to maintain their professional competency. Ten of 21 registered nurses have completed their interRAI training. There are implemented competencies specific to registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies. Seventeen of 24 caregivers who work in the dementia unit have completed their dementia qualification. The remaining seven caregivers have been working in the unit for less than one year.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Extra staff can be called on for increased residents' requirements. Additional casual staff are available if needed. 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. Caregiver's interviewed, stated that management are supportive and approachable. Staff interviewed advised that there are sufficient staff on duty at all times. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents. The village manager, deputy manager and clinical manager all work full time from Monday to Friday and are available for after hour calls 24/7.</p> <p>There are two hospital units (hospital unit one and two) and the rest home wing located on the ground floor.</p> <p>In the hospital one unit (34 hospital residents and 6 rest home) there is a unit coordinator/RN, who is supported by two RNs and eight caregivers on the morning shift, two RNs and six caregivers on the afternoon shift and one RN and three caregivers on the night shift.</p>

		<p>In the hospital two unit (17 hospital residents and 11 rest home) there is one RN and five caregivers on the morning shift, one RN and three caregivers on the afternoon shift and one RN and one caregiver on the night shift.</p> <p>In the rest home unit (42 rest home) there is a unit coordinator/RN, who is also assigned to the hospital two unit. The rest home unit coordinator is supported by one RN and four caregivers on the morning shift, four caregivers on the afternoon shift and two caregivers on the night shift.</p> <p>The dementia unit (2 x 20 bed units) is on level one. There are 34 dementia level residents in total (17 residents in each unit). There is a unit-coordinator/RN assigned to the dementia unit who is supported by one RN and four caregivers on the morning shift, one RN and four caregivers on the afternoon shift and three caregivers on the night shift. During the night shift, a hospital unit one RN provides oversight for the dementia unit and the rest home.</p> <p>There are 20 serviced apartments certified to provide rest home level of care. Two rest home level residents were living in serviced apartments during the audit. There is a serviced apartment unit coordinator/EN who is supported by two caregivers on the morning shift and two caregivers on the afternoon shift. The night shift is covered by a senior caregiver in a hospital wing (the closest to the serviced apartments). Staff communicate via mobile telecommunications.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. Specific information around dementia care services is included in the information pack as applicable for dementia care admissions.</p> <p>The four files reviewed from the dementia unit (two long-term and one under 65 years of age) had a needs assessment determining that the resident required a secure dementia unit environment. Approval</p>

		<p>had been sought from a psychiatrist.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term and short-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of monthly blister packs is completed by two RNs and any errors fed back to the pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency. Appropriate medications were signed by two medication competent staff, one of which was a RN. The service uses an electronic medication system. Care staff and RNs interviewed could describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all five units (rest home, serviced apartments, hospital, dual-purpose beds and dementia care). Medication fridges are monitored weekly. All eye drops and creams in medication trolleys were dated on opening. There are two rest home level residents self-medicating and competencies are up-to-date.</p> <p>Twenty-four medication charts were reviewed across all units on the electronic medication system. All medications 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. Care staff observed to be administering medications in the dual-purpose bed unit (hospital two) and dementia care unit were compliant. Two residents under PAC funding had paper-based medication charts and signing sheets that met legislative requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	CI	<p>All food and baking is prepared and cooked on-site. The qualified head chef is supported by one other chef, a baker and a team of kitchen assistants. Staff have been trained in food safety and chemical safety. Project "delicious" was commenced in February 2017. Menu choices are decided by residents (or staff if the resident is not able) the day before, and offer a choice of three main dishes for the midday and two choices for evening meal including a vegetarian option. Resident dislikes are accommodated.</p>

<p>met where this service is a component of service delivery.</p>		<p>Diabetic desserts, gluten free and modified meals are accommodated. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Meals are delivered in hot boxes and served from bain maries in the unit kitchenettes.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours in all units.</p> <p>Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings, survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided. Implementation of project delicious has achieved greater resident satisfaction with meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>In the files reviewed, risk assessments had been completed on admission for all residents including the resident under PAC funding. Routine interRAI assessments and planned risk assessment tools on the VCare had been reviewed six-monthly as part of the evaluation process for long-term residents. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural, wound and restraints were completed according to need. The service utilises the myRyman electronic resident individualised care programme. The assessments generate interventions and narrative completed by the RNs that are transferred to the care plan guide. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily</p>

		calendar. All assessments and interventions updated were included in progress notes.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plan/assessments on VCare outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs are met. Twelve long-term resident plans on the care guide were reviewed and recorded sufficient detail to guide staff in the delivery of care to meet the resident's goals. The residents and relatives interviewed confirmed they were involved in the development of care plans. The resident under PAC funding had an initial support plan developed with information gathered from the DHB rehabilitation team (physiotherapist, occupational therapist, community nurse and social worker as required).</p> <p>Four dementia care files were reviewed of residents in the dementia unit. All four included integrated activities of daily living that supported activities/interests across 24 hours. Behaviour management/de-escalation plans were documented on the myRyman care guide for all four residents.</p> <p>The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall. There was documented evidence of resident/family/whānau involvement in the care planning process. VCare care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record.</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>	FA	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (eg, resident turns, fluids given [sited]). Monitoring charts are well utilised. Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Wound assessments, treatment and evaluations were in place for residents with wounds. Wound assessments and management plans are completed. When wounds are due to be dressed a task is automated on the RN daily schedule. The wound champion reviews wounds. There were seven pressure injuries on the day of audit. Two pressure injuries were stage one (one rest home and one hospital) and five stage two (hospital). One stage two pressure injury was DHB acquired. The wound</p>

		<p>champion could describe access to wound specialist nurses if required. The GP reviews wounds regularly.</p> <p>Continence products are available and resident files included 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>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>There is a team of activities staff (four with diversional therapy (DT) qualifications and one activity assistant) with one each based in the individual units (dementia unit, two hospital units and rest home unit). They coordinate and implement the unit specific Engage activities programme across the four units. The programme is Monday to Friday in the rest home and serviced apartments and seven days per week in the hospitals and dementia care unit. Rest home residents in serviced apartments choose to attend the rest home programme or serviced apartment activities.</p> <p>Activities staff attend on-site and organisational in-services relevant to their roles. A facility van is available for outings for all residents. A wheelchair van is hired for hospital resident outings. The designated bus driver and the DTs hold 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 A exercises, walks, themed events and celebrations, baking, sensory activities, including pets coming to visit, student visits, outings and drives. The lounge areas have seating placed for large and smaller group activities. One-on-one activities occur, as well as regular wheelchair walks out in the gardens for those unable to participate in the group programme. Daily contact is made with residents who choose not to be involved in the activity programme. There are opportunities for residents from all units to join together for larger celebrations.</p> <p>The DT and one lounge carer provide activities in each of the units. Activities such as entertainment are held in the larger lounge for all residents. The men's club has been increased to three times a month due to popularity and some men from the hospital and rest home units join the men's group. Meaningful activities include music, pet therapy, Triple A exercises twice a day, memory lane, reflections and group games. A successful walking group has been established.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed myRyman had been evaluated at least six-monthly with the care plan review. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident and relative meetings and satisfaction surveys.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Files reviewed identified that care plans had been evaluated by registered nurses at least six-monthly. Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the VCare care plan which is then automatically transferred into the myRyman care guide. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review.</p> <p>There is also a multidisciplinary (MDT) review completed that includes people involved in the resident's care. Records of the MDT review were evident in the resident files reviewed. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care, for example, serviced apartment to rest home level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied professionals.</p> <p>Dementia files sampled included documented evidence of input from mental health services for older people, including the nurse specialist and the geriatrician, the physiotherapist and the dietitian.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry, housekeeping and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets are available. Relevant staff have completed chemical safety training. A chemical spill kit is available.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The two-level building has a current building warrant of fitness that expires 8 May 2018. On the ground level there is the care centre (hospital unit, dual-purpose unit, rest home unit and serviced apartments) and the first floor is the two dementia units. There is lift and stair access.</p> <p>The head of maintenance has been in the role 15 years and holds a current site safety certificate. Maintenance requests are addressed by the team or contractors as required. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and two yearly electrical testing. Hot water temperatures in resident areas are monitored three monthly as part of the environmental audit and are maintained below 45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is space in the hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.</p> <p>There is a team of grounds and garden staff that maintain the external areas. Residents are able to access the outdoor gardens and courtyards safely from all units. Seating and shade is provided.</p> <p>Staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including sensor mats, standing and lifting hoists, hospital level lounge chairs, mobility aids, transferring equipment, wheel-on and chair scales, pressure relieving mattresses and cushions, electric beds and ultra-low beds.</p> <p>The two dementia units are separated by a door that can be opened during the day. Both units have doors that open out onto a deck area with seating, shade and raised gardens. There is an indoor and outdoor walking pathway.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All bedrooms in all areas have single ensuites. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal</p>	<p>FA</p>	<p>All residents' rooms are single and of an appropriate size in all areas to allow care to be provided and for</p>

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each unit has a spacious lounge and dining area. There are other family rooms and seating alcoves including a library area that is available for quiet private time or visitors. The communal areas are easily and safely accessible for residents and staff. There is adequate internal and external space to allow maximum freedom of movement while promoting safety for those that wander. The service has a chapel, library service, hairdressers and shop for all residents to access. The dementia unit has doors between the units that are opened for larger activity groups or entertainment.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the Ryman programme. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Material safety datasheets are readily accessible.</p> <p>There are dedicated laundry and housekeeping staff. All linen and personal clothing is laundered on-site. Cleaners' trolleys are well equipped and stored in locked areas when not in use. Residents interviewed state they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service training programme and staff annual comprehension competency. There is a first aid trained staff member on every shift and accompanying residents on outings. The facility has an approved fire evacuation plan. Fire evacuation drills take place six-monthly, last occurring on 14 November 2017. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities (two BBQs) are in place. There are civil defence kits in each unit (hospital, rest home, dementia and serviced apartments), these are checked monthly (sighted).</p>

		There was adequate water storage on-site. The facility has two generators on-site. The call bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms. The call bell system is linked to staff pagers and to the call bell panels. Staff use a telecommunications system to answer the phone at reception after hours and to communicate with each other if assistance is needed. Call bell response times are regularly monitored and reflect acceptable response times. Security systems are being implemented to ensure residents are safe. Staff confirmed that they conduct security checks at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control committee is combined with the health and safety committee, which meets bi-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and a six-month analysis completed by the infection control and prevention officer (dementia care unit coordinator/RN) which is reported to the governing body. Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers and signage throughout the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection prevention and control committee (combined with the health and safety committee), is made up of a cross-section of staff from areas of the service. The infection control officer has completed on-line infection control training through the DHB. The facility also has access to an infection prevention and control nurse specialist from the DHB, district nurse wound specialist, public health, GPs, local laboratory and expertise from within the organisation.

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate and available to all staff on-line.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions and training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the electronic resident files. Infections are included on an electronic register and the infection prevention officer 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. The infection prevention and control programme links with the quality programme and benchmarked against other Ryman facilities. 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. A norovirus outbreak in December 2017, was well managed with an outbreak investigation log and outbreak management report. Notifications to relevant personnel were sighted.</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 was 13 residents with 14 restraints (five bed rails, seven chair briefs and two chair harnesses) and one resident using an enabler (bed rail). The resident file for the resident using an enabler reflects a restraint/enabler assessment and voluntary consent by the resident. Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Five files for residents using restraint were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints</p>

		and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in five resident files reviewed where restraint was in use. Restraint use is discussed in the clinical/RN meetings. This was confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.

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 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	In September 2016, the service commenced a programme to improve the meal service following feedback that residents were not enjoying meals.	In February 2017, the service implemented project delicious. An action plan was developed which included the chefs rotating through each dining room at meal times to serve the meals so they could identify what was not being enjoyed and make changes, chefs reading and signing the communication books located in each servery where staff, residents and families can leave comments on meals, chefs talking to residents on at least a weekly basis, working with food suppliers to improve the raw quality of the food provided, sourcing a supplier for high food value and flavoured pureed foods, and improving the dining experience including staff etiquette for residents. Project delicious was implemented with four-week rotating menus (summer and winter) providing more meal choices, which also caters for a vegetarian and gluten free option. The midday meal provides three main options and two options of desserts. Dinner provides a choice of two options. As a result of these interventions, resident surveys for hospital residents identified an improvement in meal satisfaction in the 2017 resident survey from a score of 3.20 in 2016 to 3.50 in 2017 and this improved for rest home residents from 3.52 in 2016 to 3.83 in 2017. The dementia care relative surveys identified an improvement in meal satisfaction from 4.09 in 2016 to 4.18 in 2017 with 5 being the highest rating

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>Hilda Ross continues to implement the Ryman organisational 'Engage' activities programme. An activities programme, based on the Engage concepts, is provided in the hospital units and dementia unit seven days per week and in the rest home and serviced apartments five days per week. New initiatives have been introduced and some activities provided above the requirement for the Engage programme.</p>	<p>Hilda Ross activities staff and leadership team have continued to improve the activity programme to provide resident enjoyment and participation in activities in each unit. To do this the activities team identified resident preferences and meaningful activities that could be incorporated into the programme. In Hospital two (dual-purpose unit), the service separated their activity programme from hospital one and based a DT in that unit. As the resident numbers were smaller there was an increase in resident participation in Triple A exercises, active games and "make and create". In the hospital unit, the residents continued to enjoy sensory activities such as baking, massages and pampering. The rest home unit introduced visiting students to engage with the residents. Their visits have increased from two a month with 43 residents (June 2017) to six visits per month with 130 residents (December 2017). A walking group has been set up for residents in the dementia care unit both indoors and outdoors daily, with a focus on incorporating meaningful activities such as collecting the newspaper and mail from main reception. On the weekends, the walking group go on a village walk benefiting from the fresh air and exercise. They also enjoy the gardens and recognise seasonal planting. Residents in the walking group have built friendships.</p> <p>Feedback on the activities programme from residents is sought through resident meetings and satisfaction surveys.</p> <p>Hospital and rest home residents' ratings of agreeing or strongly agreeing that they enjoy the activities programme increased slightly. The rest home relatives' satisfaction increased from 3.29 in February 2016, to 3.46 in February 2017. Hospital relatives' results increased from 3.25 in February 2016 to 3.5 in February 2017. The greatest increase was for dementia care relatives from 3.73 in February 2016, to 4.36 in February 2017 (with 5 being the highest rating).</p>
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End of the report.