

# Ernest Rutherford Retirement Village Limited

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## 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:

<b>Legal entity:</b>	Ernest Rutherford Retirement Village Limited
<b>Premises audited:</b>	Ernest Rutherford Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 30 August 2018 End date: 31 August 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	105

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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

Ernest Rutherford provides rest home, dementia and hospital level care for up to 124 residents, including 30 serviced apartments certified to provide rest home level care. At the time of the audit there were 105 residents in total.

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 at Ernest Rutherford is non-clinical and has been in the role for seven years. He is supported by an assistant to the manager and a clinical manager, who oversees the clinical care in the care centre. The clinical manager has been in the position for three months. The management team is supported by the Ryman management team including regional manager.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified two improvements required around neurological observations and care planning documentation.

The service is commended for achieving two continuous improvement ratings around the reduction of challenging behaviour incidents and pressure injury reduction.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned and coordinated, and are appropriate to the needs of the residents. A village manager, assistant to the manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence

of regular reviews. Ernest Rutherford has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Ernest Rutherford provides clinical indicator data for the three services being provided (rest home, dementia and hospital). There are human resources policies including recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes. Residents and families 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.		Some standards applicable to this service partially attained and of low risk.
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The service has a comprehensive admission pack. The systems reviewed evidenced each stage of service provision was developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a range of life experiences and choices. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs. Residents' clinical files reviewed, validated the service delivery to the residents. Where progress was different from expected, the service responded by initiating changes to the specific care plan. Allied health professionals are involved in the resident's care as applicable. Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files evidenced individual activities were provided either within group settings or on a one-on-one basis. There was an appropriate medicine management system in place. Staff responsible for medicine management attended medication management in-service education and have current medication competencies. The residents who self-administer medicines do so according to policy. All meals and baking are done on-site by qualified chefs. The menu provides choices and

accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. 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. There are six-monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on-site at all times. Housekeeping staff maintain a clean and tidy environment.

## 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 as evidenced in the two resident files with restraints reviewed. At the time of the audit there were no residents using any enablers and two residents with restraint in use. Staff receive training around restraint minimisation and the management of challenging behaviour.

## 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 (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	47	0	2	0	0	0
<b>Criteria</b>	2	97	0	2	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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-two care staff (two unit-coordinators, eight registered nurses (RNs), eight caregivers across each area 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. Twelve resident files reviewed (two dementia, six rest home, including two from the serviced apartments and one respite resident, and four</p>

		hospital) files included written consents. 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 as required. Caregivers and RNs interviewed, confirmed verbal consent is obtained when 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. Advocacy information is displayed. Residents and family have access to Age Concern representatives.
<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 community events outside of the facility. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. The village manager stated they are always working on ways to improve community involvement. Relatives and friends are encouraged to be involved with the service and care.
<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 visible at the entrance to the facility. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being

		<p>managed in a timely manner.</p> <p>The complaints process is linked to the quality and risk management system. There has been one complaint made in 2017 and five complaints received in 2018 (year to date). The village manager has responded and met with families as required. The regional manager is involved in the management for HDC or DHB complaints. The village manager monitors progress of implemented corrective actions with complainants, to ensure the complaints are resolved to the satisfaction of the complainant.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about consumer rights. There is also the opportunity to discuss aspects of the code of rights during the admission process. Five relatives (two hospital and three dementia) and ten residents (five rest home and five hospital) interviewed, confirmed that they have been provided with information on the code of rights. Large code of rights posters are displayed throughout the facility. The village manager and clinical manager reported having an open-door policy and described the process around discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being completed. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training</p>

		on abuse and neglect, last completed in June 2018.
<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. At the time of the audit there were no residents who identified as Māori. Links are established with local Māori iwi (Whakatu Marae) and other community representative groups. Family/whānau involvement is recognised and acknowledged by staff.
<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.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff across all areas, confirmed an awareness of professional boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly at head office by the appropriate person. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (head office)

		<p>for collating, monitoring and benchmarking between facilities.</p> <p>Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the team 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. Ryman Ernest Rutherford provides several examples of good practice including pressure injury prevention.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service. The information pack is available and can be read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Regular contact is maintained with family, including if an incident or care/health issues arises.</p> <p>Fifteen incident/accident forms reviewed indicated that the next of kin are routinely contacted following an adverse event. Evidence of families being kept informed is documented in the electronic database and in the residents' progress notes. All family interviewed, stated they were well-informed. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed for residents who are unable to speak or understand English.</p>
<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>Ernest Rutherford retirement village is a Ryman Healthcare retirement village. Ernest Rutherford provides rest home, dementia and hospital level care for up to 124 residents, including 30 serviced apartments certified to provide rest home level care. At the time of the audit, there were 105 residents in total, 40 rest home residents, (including 15 rest home residents in the serviced apartments) and 41 hospital level</p>

		<p>residents (including two in the rest home wing on the ground floor). All 69 rest home and hospital beds are dual purpose. There were 24 dementia level residents in the special care unit which is on level one and is accessible by lift or stairs. There was one rest home resident on respite care. There were no residents under a medical component or younger persons with disabilities (YPD) contract. All other residents were under the aged related residential care (ARCC) contract.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. The village objectives for the 2017 year have been reviewed and the 2018 village objectives in place and are reviewed every four months. A quality improvement plan register for 2017/2018, documented a number of initiatives and progress updates. There is a health and safety, and risk management programme being implemented at Ernest Rutherford.</p> <p>The village manager at Ernest Rutherford is non-clinical and has been in role for seven years. He has a management background both in health and non-health services. He is supported by an assistant to the manager who carries out administrative duties, and a clinical manager who oversees the clinical care in the care centre. The clinical manager has been in the position for three months and has previous experience in clinical manager roles. The village manager and clinical manager are supported by a hospital unit coordinator/RN, dementia care unit coordinator/RN, serviced apartment's unit coordinator/EN and the Ryman management team including a regional manager (who was present during the audit).</p> <p>The village manager has maintained at least eight hours of professional development activities related to managing an aged care facility. The village manager attends the annual Ryman manager's conference.</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</p>	<p>FA</p>	<p>The clinical manager is responsible during the temporary absence of the village manager, with support provided from the assistant to the manager and regional manager.</p>

consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Ernest Rutherford has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Minutes are maintained. Audit summaries and quality improvement plans (QIP) are completed where a non-compliance is identified. QIPs reviewed for 2017 and 2018 have been closed out once resolved. The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Ernest Rutherford provides clinical indicator data for the three services being provided (rest home dementia and hospital). Clinical indicators are graphed and displayed in the staff room, showing trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes. A resident satisfaction survey was completed in February 2018, with a high overall satisfaction rate. Quality improvement plans were evidencing that suggestions and concerns were addressed. The results of the relatives' satisfaction survey in July 2018 were not available at the time of the audit.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (RN) was interviewed. She has completed specific external health and safety training. Health and safety/infection control</p>

		meetings are conducted bi-monthly. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at management, teamRyman and staff meetings. Falls prevention strategies are in place that include; ongoing falls assessment, routine checks of all residents specific to each resident's needs (intentional rounding), encouraging resident participation in the activities programme and the use of sensor mats.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<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/accidents forms identified timely RN review and follow-up. Three of six resident falls reviewed where staff could not rule out the resident may have hit their head, neurological observations were commenced, but not completed for an ongoing period of time to rule out neurological changes. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur.</p> <p>The village manager was able to identify situations that have been reported to statutory authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (one clinical manager, three unit-coordinators, two RNs, five caregivers, one activities coordinator and one cook) included a signed contract, job description relevant to the staff members role, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for</p>



		<p>newly appointed staff. A register of RN practising certificates is maintained. Practising certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan in place for 2018. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are also required to complete a series of comprehension surveys each year. Registered nurses are supported to maintain their professional competency. Fourteen of sixteen RNs have completed their interRAI training. There are implemented competencies specific to RNs and caregivers related to specialised procedures and/or treatment, including medication competencies and insulin competencies. Caregivers are supported to complete Careerforce standards. There are twenty caregivers who work in the dementia unit. Fourteen caregivers have completed the dementia standards and the six caregivers in progress of completing have commenced work in the last 18 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>	<p>FA</p>	<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 fulltime Monday to Friday and are on call 24/7. They are supported by two-unit coordinators/RN in hospital and dementia care, and one-unit coordinator/enrolled nurse (EN), in serviced apartments. Interviews with eight caregivers (two hospital, two rest home, two dementia care and two 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 Ernest Rutherford is as follows; in the hospital unit there are 39 residents in total, 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 nine caregivers (four long and five short shifts)</p>

		<p>and fluids assistant on morning shift, seven caregivers (two long and five short shifts) and two caregivers on night shift. In the rest home unit, there are 27 residents in total (25 rest home and two hospital), there is an RN who is supported by three caregivers (two long and one short shift) on the morning and afternoon shifts and two caregivers on night shift.</p> <p>In the dementia care unit, there are 24 residents in total, there is a unit coordinator/RN who is supported by an RN on duty on the morning shift. There are three caregivers (two long and one short shift), four caregivers (two full and two short shifts) on the afternoon shift and two caregivers on night shift. The hospital RN covers the rest home and dementia units on the afternoon and night shifts.</p> <p>In the serviced apartments, there are 15 rest home level residents in total, there is a unit coordinator/EN who is supported by three caregivers (two long and one short shift) on the morning shift and three caregivers (one long and two short shifts) on the afternoon shift. The rest home caregivers and hospital RN cover the serviced apartments on the night shift.</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>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or RN including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. Information specific to this service is recorded and communicated to residents, family, relevant agencies and staff. The facility information pack is available for residents and their family and contains all relevant information including specific information on the dementia care unit. Residents' admission agreements evidenced resident and/or family and</p>

		<p>facility representative sign off. The needs assessments were completed for rest home, hospital and dementia levels of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner and all relevant admission information was provided and discussed, including charges not included in the services provided.</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>There was appropriate communication between families and other providers in the residents' files that demonstrated transition, exit, discharge or transfer plans were communicated, when required. Transition, exit, discharge, or transfer form/letters/plan were located in residents' files, where this was required. One rest home file reviewed demonstrated a seamless admission to the hospital. GP was informed of resident decline, resident was reviewed and admission to hospital was arranged, relative was informed, transfer documentation was completed and copy in file. Registered nurses interviewed described the process involved on admission and discharge of a resident from hospital including verbal handovers, interRAI, and medication management. Faxes and discharge documentation were on file.</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, ENs and senior care assistants who administer medications have been assessed for competency. Education around safe medication administration has been provided annually. The service uses an electronic medication system. Medications were stored safely in all units. Medication fridges are monitored weekly. All eye drops and creams in medication trolleys were dated on opening. There were two residents self-medicating on the day of audit and both residents had signed medication competencies on file.</p> <p>The medications were adequately stored in resident rooms. Twenty-four medication charts were reviewed (four dementia, ten hospital and</p>

		<p>ten rest home). Both long-term and respite resident medication charts were on the electronic medication system. All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP (for permanent residents). Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The qualified head chef is supported by a second chef on duty, cook's assistants and kitchenhands. Staff have been trained in food safety and chemical safety. All meals and baking are prepared and cooked on-site. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Project "delicious" has been in place since February 2017. Menu choices are decided by residents (or primary care staff if the resident is not able) and offer a choice of three main dishes for the midday meal and two choices for the evening meal including a vegetarian option. Diabetic desserts and gluten free diets are accommodated. Meals are delivered in hot boxes to each unit satellite kitchen and plated by care staff. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident dislikes are accommodated and listed on the daily spreadsheet. Alternative foods are available on the menu or offered.</p> <p>Cultural, religious and food allergies are accommodated. Nutritious snacks are available after hours. There is a supply of snacks in the dementia unit. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded daily. The chilled goods temperature is checked on delivery. Twice daily food serving temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained for the cook and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing. The food control plan has been registered and verified. Residents can provide feedback on the meals through resident meetings, food communication books in each servery, resident survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The potential resident would be referred back to the referring service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment and care plan on admission including relevant risk assessment tools. The service has introduced the myRyman electronic resident individualised care programme. There are a number of assessments completed that assess resident needs holistically. The assessments generate interventions and narrative completed by the RNs that are transferred to the care plan. 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 calendar. All assessments and interventions updated were included in progress notes (link 1.3.5.2). InterRAI assessments were completed within 21 days of admission as sighted in 11 long-term resident files. One respite file (rest home level) contained initial assessments, risk assessments and care plans. The facility has processes in place to seek information from a range of sources, for example, family, GP, specialist, previous hospital discharge documentation and the referrer. The residents' files evidenced residents' discharge/transfer information from the district health board (DHB).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The care plans reviewed were individualised and up-to-date. The residents' files were in hard copy, with all assessments, wound documentation, and monitoring charts recorded on the electronic VCare system. The myRyman Care electronic system care interventions reviewed reflected the assessments and the level of care required. The long-term care plan is updated to reflect current changes to resident conditions, however not all plans had been updated as required. There was evidence of allied health care professionals involved in the care of</p>

		<p>the resident, including physiotherapist, podiatrist, dietitian, older persons health, geriatrician, and wound care nurse.</p> <p>In interviews, staff reported they received adequate information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented as sighted in current GP progress reports.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a nursing review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>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, (e.g., resident turns, fluids given). 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 (link 1.3.5.2).</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. There were no current pressure injuries. The service has implemented a proactive management plan for all at residents at risk of pressure injuries and early identification and management has been comprehensive. RNs interviewed confirmed wound nurse specialist involvement when required.</p>

		<p>At the time of the audit there were 21 wounds (two rest home, seven dementia and twelve hospital level), which included non-healing chronic ulcers, skin tears, lesions and other superficial wounds. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. There is a suite of monitoring forms available on the VCare system which link into myRyman. These include weight, vital signs, behaviour monitoring and assessment, pain, neurological observations and blood glucose monitoring.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities team at Ernest Rutherford includes three diversional therapists and four activities coordinators. Activities are available in the hospital, rest home and dementia unit between 9.30 am and 8.00 pm across seven days a week. An activities officer is based in the serviced apartments and provides an activities programme between 9.30 am and 4.30 pm, Monday to Friday. Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident and relative meetings and satisfaction surveys.</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 (but not limited to); Triple A exercises, board games, news and views, make and create, memory lane, baking, men's group, sensory activities including pet therapy, themed events and celebrations. Rest home residents in serviced apartments can attend either the serviced apartment or rest home/hospital programmes.</p>

		<p>Some activities are integrated for all residents including entertainment, special days such as the Melbourne Cup and other celebrations. The service has regular visits from a local school where the children actively participate in activities such as photo identification games with the residents.</p> <p>Van outings include (but are not limited to) visits to local events, museums, cafés, gift shops, and picnics. In interviews, the activities coordinators confirmed the activities programme meets the needs of the service group and the service had appropriate resources. Ryman distributes an annual activities calendar providing guidance and support to the recreational team. The diversional therapists and the activities coordinators plan, implement and evaluate the activities programmes. There are activities programmes for each service at the facility. Regular exercises and outings are provided for those residents able to partake. Interviews with residents, family and staff confirmed the activities programme included input from external agencies and supported ordinary unplanned/spontaneous activities, including festive occasions and celebrations. There were activities assessments, care plans and care plan evaluations in residents' files reviewed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly or more often when the resident condition changed. There was evidence of multidisciplinary input in care plan evaluations against the resident goals. Overall care plans had been updated to reflect any changes in care (link 1.3.5.2). Residents and family confirmed their participation in care plan evaluations. The GP reviews the residents at least three monthly or earlier as required.</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. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP,</p>



		Ryman specialists, nurse specialists, hospice and contracted allied professionals.
<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>	FA	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets are available. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The two-storey building accommodates a care centre and serviced apartments. The building has a current warrant of fitness that expires 20 January 2019. The head of maintenance oversees maintenance and repairs. All requests are recorded in a register held at the main reception (sighted), which has been signed off as requests have been addressed. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, electrical testing (bi-annually) of electric beds and hoists and electrical testing. There are essential contractors available 24/7. The maintenance manager is available on-call for urgent facility matters. Hot water temperatures in resident areas are monitored three monthly as part of the environmental audit and stable below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids.</p> <p>There is adequate storage and space in the rest home and hospital wings for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. 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 both wings. Seating and shade is provided. The dementia unit has a safe internal courtyard with entry/exit points from the lounge and conservatory with seating and shade. The outdoor area is currently being redecorated and raised garden beds are being replanted. Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in</p>

		the resident care plans including; sensor mats, standing and lifting hoists, hospital lounge chairs, mobility aids, transferring equipment and pressure relieving mattresses and cushions.
<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>	FA	All bedrooms are single with full ensuites. There are adequate numbers of communal toilets (located near the communal areas). Communal toilets have privacy slide signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All residents' rooms are spacious enough to allow care to be provided safely and for the safe use and manoeuvring of hoists in dual-purpose rooms. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Each area has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library available for quiet private time or visitors. There are communal areas including large lounges, small lounges and several seating alcoves throughout the facility. There is a separate dining area in the large open plan living area in the secure unit. The service has a library service, hairdressers and shop for all residents to access. The communal areas including the grounds and internal courtyards, are easily accessible.
<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	The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed as per the internal audit programme. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. The laundry has an entry and exit door with defined clean/dirty areas. All personal clothing is laundered on-site by dedicated laundry staff. Larger items such as sheets are processed by

		<p>a contracted company who pick up and deliver.</p> <p>There are colour coded linen bags and all linen and personal clothing items are sorted prior to washing. There are designated cleaning persons on duty each day. Cleaners' trolleys (sighted) were well equipped and stored in locked cupboards when not in use. All chemical bottles have the correct manufacturer's labels. Residents interviewed stated they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings, annual surveys (resident and relative) and the results of internal 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 is an emergency and disaster management plan in place to guide staff in managing emergencies and disasters. Staff emergency and disaster management training is provided to staff. There is a first aid trained staff member on every shift and accompanying residents on outings. There is an approved fire evacuation plan dated 16 December 2008. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 31 May 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked six monthly.</p> <p>Sufficient water is stored for emergency use and alternative heating and cooking facilities (four BBQs) are available. There is a generator to cover the care centre and the village if there is a power failure. Smoke alarms, sprinkler system and exit signs are in place. The facility is secured at night. There are call bells in all resident rooms, toilet/shower areas and communal areas. Visitors and contractors sign in at reception when visiting. Visitors and contractors sign in at reception when visiting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is underfloor heating throughout the facility. The service has consulted an electrician regarding individually thermostat-controlled switches in all resident rooms. All rooms have external windows with plenty of natural sunlight. Residents and relatives</p>

		confirmed satisfaction with the temperature of the facility.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is a RN with a job description that defines the responsibility of the role. The infection prevention and control committee are combined with the health and safety committee, which meets two monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and the infection control and prevention officer provides a monthly report to the clinical manager. The clinical manager reports to the governing body. Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control committee (combined with the health and safety committee), is made up of a cross-section of staff from areas of the service including maintenance, kitchen and cleaning staff. The infection control officer has completed a skype infection control education session in April 2018. The infection control and prevention officer has access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
Standard 3.4: Education	FA	The infection control officer is responsible for coordinating/providing

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits six monthly. Infection control is an agenda item on the full facility and clinical meeting agenda. 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>Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings. The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There is close liaison with the GPs and the laboratory service that advise and provide feedback and information to the service. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility. The service has been successful in reducing the number of urinary tract infections (UTI). There has been one confirmed norovirus outbreak in March 2018 and one gastroenteritis outbreak in July 2017. Relevant authorities were notified. Daily case logs, minutes of meetings and correspondence were sighted. Staff were debriefed following the outbreaks and corrective actions were implemented and signed off when completed.</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>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 using any enablers and</p>

		two residents with restraint in use (chair briefs). Staff receive training around restraint minimisation and the management of challenging behaviour.
<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>	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (unit coordinator/hospital) 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>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	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. Two files for the residents using restraint were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	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 is conducted annually, 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 and enablers.

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

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	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/accidents forms identified timely RN review and follow-up. However, neurological observations were not completed for three of six resident falls reviewed that resulted in a potential head injury.	Fifteen accident/incident forms were reviewed in total. Six of the fifteen accident/incident forms reviewed were for resident unwitnessed falls with a potential head injury. Three of six resident falls reviewed where staff could not rule out the resident may have hit their head, neurological observations were commenced, but not completed for an ongoing period of time to rule out neurological changes.	<p>Ensure that neurological observations forms are fully completed for any resident fall where the resident may have potentially hit their head.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve</p>	PA Low	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	One resident in the apartment was being treated for a chest infection. This was not documented in the care plan nor was there a timely clinical entry in the progress notes.	Ensure resident care plans and progress notes reflect changes in resident's health.



<p>the desired outcomes identified by the ongoing assessment process.</p>		<p>acute needs such as (but not limited to); wound or recent fall. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record. Residents are seen three monthly by a GP and/or NP three monthly or sooner if there is a change in health. Interventions as requested by medical staff are implemented, One of the eleven files reviewed was not updated to reflect a chest infection.</p>		<p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	Ryman Ernest Rutherford provides several examples of good practice including pressure injury prevention.	<p>The service identified that pressure injuries with early detection are minimised through early reporting and prompt intervention. In March 2017, a project commenced to address this issue. The action plan included review of pressure injury equipment for residents noted to be at risk according to water low scores, ongoing education on prevention and detection, improved skin care management for residents, review of pressure injuries monthly, clinical review of all pressure injuries and ongoing discussion at all full facility and team Ryman management meetings. Early reporting on incident and accident forms was encouraged through training and monitoring to ensure that early intervention is analysed.</p> <p>Photos are taken pre, and post intervention, wound plans are created by the registered nurse, and care plans are updated then evaluated and reviewed at registered nurse meetings for educational purposes. Education of</p>

			<p>detection has been given to staff for early reporting, along with wound education. Service provision has continued to improve and has focused on identifying pressure injuries at stage one and reducing the risk of stage two or higher, pressure injuries. The number of grade one pressure injuries has been maintained at a low level and grade two pressure areas has significantly decreased. There has only been one facility acquired stage three pressure injury since February 2017 at Ernest Rutherford.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. One QIP reviewed, reflected a reduction in resident's incidents of challenging behaviour in the care centre.</p>	<p>The achievement of the rating that service provides an environment that encourages managing and analysing quality data beyond the expected full attainment. The service has conducted a number of QIPs where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.</p> <p>In May 2017 the service identified an improvement was required around a high number of incidents of challenging behaviour in the dementia unit (special care unit). A QIP was developed which included strategies and actions to reduce the number of incidents of challenging behaviour in the dementia unit. The plan has been reviewed monthly and discussed at clinical staff meetings. The service has been successful in reducing and better managing incidents of challenging behaviour within the dementia unit. A review of the data for the period from April 2017 ending in July 2018, evidenced a reduction from 6.7 incidents of dementia care residents challenging behaviours in April 2017 to 1.3 in July 2018.</p>

End of the report.