Grace Joel Retirement Village Limited - Grace Joel Retirement Village

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Grace Joel Retirement Village Limited
Premises audited:	Grace Joel Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 October 2018 End date: 26 October 2018

Proposed changes to current services (if any): Four serviced apartments adjacent to the hospital wing were assessed as suitable as dual-purpose rooms.

Total beds occupied across all premises included in the audit on the first day of the audit: 100

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ryman Grace Joel provides rest home and hospital level care for up to 129 residents and on the day of the audit there were 100 residents. The service is managed by a village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and general practitioner. This audit also included verifying four serviced apartments adjacent to the hospital wing as suitable to be used as dual-purpose beds.

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

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

Care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required and these are being implemented.

A continuous improvement rating continues to be awarded around the activities programme.

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.

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, clinical manager, unit coordinators and an assistant village manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. 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.

The building holds a current warrant of fitness. Preventative and reactive maintenance occurs. There is an approved fire evacuation scheme. There are six-monthly fire drills.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There was one resident with restraint and three residents with enablers at the time of 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 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)
Standards	1	15	0	0	0	0	0
Criteria	1	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Interviews with all seven residents (five rest home including one in a serviced apartment, and two hospital) and family, confirmed their understanding of the complaints process. Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction. Interviews with three managers (village manager, assistant village manager, clinical manager) and sixteen staff (four care assistants, four registered nurses (RNs), four activities coordinators, one physiotherapist, one head chef and two unit-coordinators) confirmed their understanding around the processes implemented for reporting and managing complaints. There are three complaint registers (rest home, hospital and village) that includes all written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The service is currently responding as required, to a health and disability complaint. The complaints process is linked to the quality and risk management system. Staff advise complaints are discussed at all staff meetings.
Standard 1.1.9: Communication	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		their family on entry to the service and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Regular contact is maintained with family, including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All three family members interviewed (one hospital level and two rest home level) stated they were always well-informed. Fourteen incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Interpreter services are available if needed for residents who are unable to speak or understand English. There were three residents with English as their second language.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Grace Joel is a Ryman healthcare retirement village located in Auckland. They are certified to provide rest home and hospital levels of care for up to 99 residents. In addition, there are 30 serviced apartments certified to provide rest home level care. This audit also included verifying four serviced apartments situated next to the hospital unit as suitable to provide either rest home or hospital level care. Occupancy during the audit was 100 residents (32 rest home and 59 hospital residents in the care facility, and nine rest home in the serviced apartments). Two residents were on respite contracts (one rest home and one hospital) and one resident in the rest home was under a residential disability- intellectual contract. All other residents were on the ARCC contract. 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. The village manager is non-clinical and has been employed by Ryman for one year. He has been in his current role since September 2017 and previous to this role had experience in education and teaching at a managerial level. The village manager is supported by a regional manager, clinical manager/RN, 2 x unit coordinators/RN and an assistant village manager. The clinical manager (CM) has four years nursing experience at Grace Joel. The village manager and CM have attended over eight hours (year to date) of professional development activities related to managing an aged care facility.
Standard 1.2.3: Quality And Risk Management	FA	Grace Joel continues to implement the TeamRyman Programme, which links key components of the quality management system to village operations. There are monthly TeamRyman committee meetings. Outcomes from the TeamRyman committee are then reported across the various meetings including (but not limited to) the full

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		facility, registered nurse (RN) and care assistants. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Clinical meeting minutes were sighted. Interviews with staff confirmed an understanding of the quality programme. Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced-based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room. A relative survey was last completed in September 2018 and a care centre residents survey in March 2018. Results have been collated with annual comparisons for each service. Areas of concern were identified around laundry and housekeeping, and quality improvement plans (QIPs) raised, completed and signed off. Results were fed back to participants through resident and relative meetings. TeamRyman prescribes the annual internal audit schedule that is being implemented at Grace Joel. Audit summaries and QIPs are completed where a non-compliance is identified (<90%). Issues and outcomes are reported to the appropriate committee (eg, health and safety). Quality improvement plans reviewed were closed out once resolved. Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is trending of clinical data and development of QIPs when volumes exceed targets (eg, falls). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The combined health and safety and infection control committee meet bi-monthly and incidents/accidents, falls and infections is discussed and documented. The health and safety officer interviewed described the role of the health and safety committee. There is a current hazard register.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and	FA	There is an incident reporting policy that describes all processes of incident reporting. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of 16 incident/accident forms for September and October 2018 identified that all were fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the applicable meetings (TeamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur. The village manager is able to identify situations that would be reported to statutory authorities (4 x section 31 for pressure injuries sighted). There have been no outbreaks since the previous audit.

where appropriate their family/whānau of choice in an open manner.		
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, three registered nurses, three care assistants, one chef, one maintenance) provided evidence of signed contracts, job descriptions 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. Practicing certificates for other health practitioners are retained to provide evidence of registration. An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses attend two-monthly journal club. Caregivers are supported to complete Careerforce training. Registered nurses are supported to maintain their professional competency. Eleven of fifteen RNs, two unit-coordinators and one clinical manager have completed their interRAI training. Staff training records are maintained. There are implemented competencies for RNs and care assistants related to specialised procedures or treatments including medication competencies and insulin competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. There is a pool of casual staff to cover unplanned absences. The village manager and clinical manager work full time Monday to Friday and are on call 24/7. They are supported by an assistant manager, two unit-coordinators/RN (rest home and hospital) and one unit-coordinator/senior care assistant (serviced apartments). Interviews with four care assistants (two hospital and two rest home) 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 sufficient staff to meet resident needs. Staffing at Grace Joel is as follows; In the hospital, there are 38 hospital and 7 rest home residents. There is a unit coordinator/RN who is supported by two RNs on duty on the morning and afternoon shifts, and one RN on night shift. There are ten care assistants (six full and four short-shifts) and fluids assistant on morning shift, six care assistants (two full and four short-shifts) and a lounge carer on afternoons and three care assistants on night shift.

		In the rest home unit, there are 21 hospital and 25 rest home residents, there is a unit coordinator/RN who is supported by an RN on duty on the morning shift. There are four care assistants (two full and two short-shifts), five care assistants (three full and two short-shifts) and two care assistants on night shift. In the serviced apartments, there are currently nine rest home residents. There is a unit coordinator on the morning shift Tuesday to Saturday and a senior care assistant on Sunday and Monday. There are three care assistants (one full and two short-shifts) on morning shift and three care assistants (one full and two short-shifts) and three care assistants on afternoon shift. The hospital RN and care staff covers the serviced apartment on night shift. The four serviced apartments verified as hospital are located adjacent to the hospital wing. Activities are provided five days a week for rest home and serviced apartment residents and seven days a week for hospital level residents. A registered physiotherapist is available three hours per day Monday to Friday and a physiotherapy assistant carries out the rehabilitation programmes developed by the physiotherapist. There are separate laundry and cleaning staff.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit. All policies and procedures had been adhered to. There were no standing orders. There were no vaccines stored on site. The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. All staff have up-to-date medication competencies and there has been medication education this year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature in each area is checked daily. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. ‘As required’ medications had indications for use prescribed. The effectiveness of ‘as required’ medications is recorded in the progress notes and on the electronic medication system.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs	FA	The qualified head chef is supported by two further cooks and five kitchenhands. Staff have been trained in food safety and chemical safety. All meals and baking are prepared and cooked on-site. The food control plan has been verified and expires 16 October 2019. The seasonal menu has been designed in consultation with the dietitian at an organisational level and seeks feedback from residents. Project “delicious” has been in place since 2017. Menu choices are decided by residents (or primary care staff if the resident is not able) and offer a variety of choices. Diabetic desserts and gluten free diets are accommodated as required. Meals are delivered in hot boxes and served from bain maires in the unit kitchens. The cook receives a resident dietary profile for all new admissions and

are met where this service is a component of service delivery.		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. Cultural, religious and food allergies are accommodated. Fortified meals are provided on RN/dietitian request. Pureed foods are brought in that have a higher nutritional value. Each dining room has baskets of fruit. Freezer and chiller temperatures and end-cooked, re-heating and serving temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents can provide feedback on the meals through resident meetings, resident survey and direct contact with the head chef. Residents and relatives interviewed spoke positively about the choices and meals provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents interviewed (five rest home and two hospital) 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. 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 care assistant to complete. Individual surface devices in each resident room allows the care assistant the opportunity to sign the task has been completed, (eg, resident turns, fluids given [sighted]). 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. Resident falls are reported electronically and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their head. Family are notified. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. There are currently twenty-two minor wounds being treated. There are currently two stage one, two stage two and one (non-facility acquired) stage four pressure injuries. A review of all five, identified documentation was fully completed. An S31 has been completed for the stage four. There has also been input from the GP and district nurse and photos of progress has been taken. Pressure injury prevention equipment is available and is being used. Care assistants document changes of position on myRyman.
Standard 1.3.7:	CI	There is an activities coordinator in every wing, each working 32.5 hours a week. There is an additional activities coordinator who works between the Hauraki and Waitemata wings for fourteen hours a week. Two activities

Planned Activities 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.		coordinators are diversional therapists and two are currently completing the diversional therapy course. On the days of audit, residents in all units were observed doing Triple A exercises, listening to entertainment taking part in quizzes and going on van outings. There was also a visit from a marae. There is a monthly programme for each unit in large print on a noticeboard, a weekly programme in large print on whiteboards and all residents also have a copy in their rooms. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside. The rest home, hospital and serviced apartments combine for some activities. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There are van outings twice weekly in all areas. There is a church service every Tuesday (one-week Presbyterian and the next Anglican). Catholic services are held on a Saturday morning. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and the Melbourne Cup are celebrated. There is pet therapy every six weeks. There is community input from pre-schools, schools, a local marae and a local parish choir. Residents go out to the RSA, stroke club and craft clubs. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held two monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Six long-term care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. One respite resident had not been at the service long enough for a review. Acute care plans for short-term needs (in myRyman) are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, CG, GP and resident/family if they wish to attend. There are one to three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are invited to the MDT review and if unable to attend are informed of any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	FA	The building holds a current warrant of fitness which expires 13 November 2018. Preventative and reactive maintenance occurs. Contractors are available when required. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and are within the acceptable range. There is an approved fire evacuation plan and six-monthly fire drills. Staff interviewed, stated they have adequate equipment to safely deliver care for rest home and hospital level of

accessible physical environment and facilities that are fit for their purpose.		care residents. The four serviced apartments on level 2 that have been approved as dual hospital/rest home beds are fit for purpose. The serviced apartments are adjacent to the hospital wing and very accessible for staff. The ensuites are sufficiently large enough to allow shower chairs and hoists if required. There is a call bell system in place and pendants are available.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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 resident files. Infections are included on an electronic register and the infection prevention and control officer (registered nurse) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were three residents voluntarily using enablers and one resident with a bedrail restraint. Restraint and challenging behaviour education is included in the 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 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Ryman Grace Joel identified in 2015 that improvements were required to improve resident satisfaction with the activities programme. Since that time the activities team has continued to provide an interesting and varied programme, which has resulted in continued levels of satisfaction. The 2018 resident and relative survey results demonstrate the service has continued to increase satisfaction with the activities programme.	The activities team, with the support of management, continues to develop new initiatives further enhancing the activities programme. The team shares skills and ideas between the areas and encourages participation of all residents. The latest initiative commenced the second day of audit (but planned over several weeks prior) is to make use of the swimming pool and encourage residents to participate in aqua-aerobics with a trained instructor. They had six residents on the first day, but more are keen if they swap days, so it doesn’t coincide with a van outing. In addition, the Friday night ‘fine dining’ experience is now a regular occurrence. There is often a theme for the night and entertainment. The February 2018 resident satisfaction survey showed a 4.5% increase in resident satisfaction for activities. The July 2018 family satisfaction survey showed a 3.75 % increase in family satisfaction with activities. The facility continues to improve and consistently exceeds the Ryman benchmark for activities.

End of the report.