

Yvette Williams Retirement Village Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Yvette Williams Retirement Village Limited
Premises audited:	Yvette Williams Retirement Village Limited
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 December 2018 End date: 13 December 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	90

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Yvette Williams is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital and psychogeriatric level care for up to 122 residents. On the day of the audit, there were 90 residents.

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, family, management, staff and a general practitioner.

The village manager is appropriately qualified and experienced and is supported by a clinical manager/registered nurse. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

There were three areas of continuous improvement awarded around food services, laundry services and reducing urinary tract infections.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (eg, 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 a Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets timeframes established by HDC.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews.

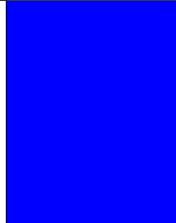
A comprehensive quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided seven days a week, twenty-four hours a day. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.
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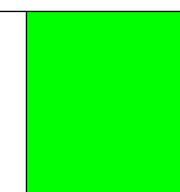
There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate 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.

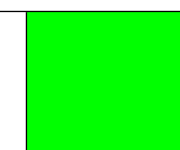
All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have ensembles. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.

The service had four residents assessed as requiring the use of restraint and two residents assessed as requiring an enabler. Staff regularly receive 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.
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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 comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. 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	49	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as part of the annual in-service calendar.</p> <p>Interviews with sixteen staff (six caregivers on the am and pm shifts (three rest home/hospital, two psychogeriatric (PG), one serviced apartments), four nursing staff (two-unit coordinators (UCs), two staff registered nurses (RNs), one cook, one maintenance, one laundry, one household staff, two activities staff) confirmed their understanding of the Code and could describe how the Code applies to their job role and responsibilities. Ten residents interviewed (three rest home- with one in a serviced apartment and seven hospital level) and six relatives (one serviced apartment/rest home, two hospital and three psychogeriatric) confirmed that the residents' rights are upheld.</p> <p>Staff were observed respecting residents' privacy and supporting residents in making choices as able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all ten resident files reviewed (two rest home including one respite and one serviced apartment, four hospital including one on ACC, and four psychogeriatric). Discussions with staff confirmed</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>that they are familiar with the requirements to obtain informed consent for entering rooms and personal care.</p> <p>Enduring power of attorney (EPOA) evidence is filed in the residents' charts. All residents in the PG unit have an activated EPOA.</p> <p>Advanced directives are signed for separately as part of the admission process. General consent forms were sighted in all ten files.</p> <p>All residents have signed admission agreements.</p>
<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>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed that they are aware of their right to access independent advocacy services. Discussions with relatives confirmed that the service provided opportunities for the family/EPOA to be involved in decisions. The residents' files reviewed included information on residents' family/whānau and chosen social networks.</p> <p>Links are in place with a local HDC advocate who regularly attends residents' and family meetings. She also visits residents informally on a regular basis to have a chat.</p>
<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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting hours. Visitors were observed coming and going during the audit. Residents are assisted to meet responsibilities and obligations as citizens (eg, voting, participating in the census). Residents are supported and encouraged to remain actively involved in community and external groups where able. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with the residents and family confirmed their understanding of the complaints process.</p> <p>There is a complaint (feedback) register that includes written and verbal complaints, dates and actions taken. Four complaints were received in 2018 (year to date). All four complaints were managed in an appropriate and timely manner as determined by HDC and were signed off as resolved. The complaints process is linked to the quality and risk management system. Staff are kept informed regarding complaints received.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Posters displaying the Code and advocacy information were sighted. The information pack is discussed with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment of 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>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>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 and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered.</p> <p>Interviews with caregivers and RNs described how choice is incorporated into resident care provision.</p>
<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	<p>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. Community links with Māori/iwi are in place.</p> <p>Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with the disability sector and other community representative groups as requested by the resident/family. Cultural needs are addressed in the resident's electronic care plan (myRyman). At the time of the audit, no residents identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the resident's electronic care plan (myRyman). Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their cultural values and beliefs.</p>

recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. Staff sign a code of conduct/house rules document during their induction to the facility. The monthly full facility meetings include discussions on professional boundaries and concerns as they arise. Interviews with three managers (village manager, clinical manager and regional operations manager) and staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data is collected against each service level. It is reported through to head office (Ryman Christchurch) for collating, monitoring and benchmarking between facilities. Indicators include (but are not limited to): resident incidents by type; resident infections by type; staff incidents or injuries by type; and resident and relative satisfaction. Feedback is provided to staff. Quality improvement plans (QIPs) are developed where results do not meet targets.</p> <p>MyRyman electronic resident information (eg, care plans, monitoring charts) have been implemented that allow for more one-on-one time with residents and less paper-based documentation. Interventions (eg, weight management, falls management strategies, pain management, behaviour management) documented on myRyman are implemented and are reviewed daily by a registered nurse. MyRyman care plans provide evidence to indicate when cares are being delivered. Interviews with care staff confirmed that the myRyman system allows for a greater amount of time to be spent reviewing the care plan with the resident in the resident's room and assists caregivers in remembering to record when specific cares are being delivered (eg, turning charts, food and fluid intake and output). Another positive aspect of the myRyman system is notification to the care staff when there is a change to the resident's care plan.</p> <p>Two general practitioners regularly visit the facility two times per week with 24/7 on-call services in place. Links are embedded with allied health professionals and the DHB specialist services (eg, Mental Health Services for Older People).</p> <p>The health and safety programme has adopted a 'stop and think' employee campaign to involve staff to a greater degree.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Regular contact is maintained with family including if an incident or care/health issues arises. Evidence of families being kept informed is documented on the electronic database. All family interviewed stated they were well-informed. Fifteen incident/accident forms on an electronic database (V-care) were reviewed and all identified that the next-of-kin were contacted following an adverse event. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. HDC advocacy services attend meetings six-monthly.</p> <p>Interpreter services are available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Yvette Williams is a Ryman healthcare village located in Dunedin. The care centre provides rest home and hospital levels of care (geriatric and medical) for up to 60 residents (all dual-purpose), and psychogeriatric (PG) care for up to 30 residents. During the audit, there were 89 residents in the care centre (5 rest home, 54 hospital and 30 psychogeriatric). There are also 32 serviced apartments certified to provide rest home level care with one rest home level resident occupying a serviced apartment at the time of the audit. One resident (rest home) was on respite and one resident (hospital) was on ACC. The remaining residents were on the aged residential care contract (ARC) or aged residential hospital specialised services contract (ARHSS).</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2018 are documented with evidence of regular reviews.</p> <p>The village manager has been employed by Ryman for five years. She attends over eight hours per annum of professional development activities related to managing an aged care facility. The village manager is supported by a full-time clinical manager/RN and a regional operations manager.</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</p>	<p>FA</p>	<p>The clinical manager is responsible for operations during the temporary absence of the village manager. The unit coordinators/RNs are responsible for clinical operations during the temporary absence of the clinical manager.</p>

of timely, appropriate, and safe services to 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>Yvette Williams has a well-established quality and risk management system that is directed by head office (Ryman Christchurch). Quality and risk performance are reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff, and review of management and staff meeting minutes reflect their involvement in quality and risk activities.</p> <p>Family meetings are held six-monthly and resident meetings are held every two months. Minutes are maintained. Annual resident and relative surveys are completed. Survey results for 2018 indicate the residents and families are satisfied with the services received. Where opportunities for improvements are identified (eg, communication), quality improvement plans are completed around survey results with evidence to confirm that suggestions and concerns are addressed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. 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. There are clear guidelines and templates for reporting. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Corrective actions are implemented and signed off where internal audit results reflect less than 95% compliance. Quality improvement projects (QIPs) are implemented where opportunities for improvement are identified with several examples provided (eg, increase in residents' falls, issues relating to communication, restraint monitoring and assessments). QIPs are signed off by the village manager when completed.</p> <p>Health and safety policies are implemented and monitored via the two-monthly health and safety meetings. A health and safety officer is appointed who has completed external stage one health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. The hazard register indicates that identified hazards are regularly reviewed.</p> <p>Resident falls are monitored monthly with strategies implemented to reduce the number of falls (eg, falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all long-term residents; routine checks of all</p>

		residents specific to each resident's needs (intentional rounding); the use of sensor mats; and increased staff awareness of residents who are at risk of falling). Lounge carers monitor residents in the lounges during the PM shift when activities staff are not available.
<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>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>Fifteen incident/accident reports reviewed identified that all are 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 (eg, team Ryman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities with three examples provided.</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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (Three caregivers, two lounge assistants, six RNs, one activities staff and one cook) provided evidence of the employment process including interviewing, police vetting and reference checks. Also sighted in the staff files were signed employment contracts, job descriptions, completed orientation programmes and annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are also retained to provide evidence of registration.</p> <p>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 training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. In-services and staff meetings are offered at different dates/times to encourage staff to attend.</p> <p>Twenty-four caregivers work in the psychogeriatric unit. Twenty caregivers have completed an NZQA approved dementia qualification (eg, Careerforce dementia-specific qualification or a national certificate in residential disability). One caregiver has completed their assessments and their papers are being marked, and the remaining three have been employed to work in the unit for less than 18-months and are enrolled to</p>

		<p>complete their dementia qualification.</p> <p>RNs are supported to maintain their professional competency. Eleven of twenty-eight RNs have completed their interRAI training. Staff training records are maintained. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Registered nurses also complete training through the Ryman journal club.</p> <p>Outbreak management training took place in March 2018 (eight attended) and infection prevention training took place in April 2018 (53 attended).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>In addition to the village manager and clinical manager/RN who both work full-time (Monday-Friday), there are three UCs. One UC/RN is responsible for the hospital/rest home residents, one UC/RN is responsible for the psychogeriatric residents and one UC/EN is responsible for the serviced apartment residents.</p> <p>The PG unit (30 residents) is staffed with an RN and an EN seven days a week. This is in addition to the UC. On the two days that the UC is not available, the CM or the hospital UC take responsibility. Of the caregivers the morning shift, there are three long-shifts and three short-shifts. On the afternoon shift, there are two long-shifts and three short-shifts an additional lounge caregiver, and one long-shift and one short-shift caregiver. The short-shift CG on the night shift shares time between the PG and hospital units. There is one RN rostered on the PM shift and one RN on the night shift.</p> <p>The hospital/rest home (53 hospital and 5 rest home) is divided into three wings with 20 beds in each wing (Tyne wing = 18 hospital and 2 rest home; St John wing = 18 hospital and 1 rest home; and Highgate wing = 18 hospital and 2 rest home). One staff RN is assigned to each wing on the AM shift. Two staff RNs are rostered during the PM shift and one staff RN is rostered on the night shift. Caregiver staffing is determined at a ratio of one caregiver to five residents on the AM shift with an additional fluid assistant. The PM shift is staffed with eight caregivers (three long and five short-shifts with the long-shift caregivers rostered to a wing each). A fluids assistant and lounge carer assist during the PM shift. The night shift is staffed with one RN and four caregivers.</p> <p>The 32 serviced apartments had only 1 rest home level resident. In addition to a UC/EN responsible for the serviced apartments five days a week, a senior caregiver covers the remaining two days of the week. An additional caregiver staff works a short shift on the AM shift. The PM shift is staffed with one caregiver until 9pm. After 9pm, a caregiver in the rest home/hospital is assigned to answer any call bells in the serviced apartments. Caregivers and RNs carry cell phones that act as a pager system for communication purposes. Cell phones are linked to the call bell system.</p>

		<p>Activities are provided seven days a week for all residents in the care centre. A registered physiotherapist is available three days a week totalling twelve hours. There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Caregivers interviewed stated that overall the staffing levels are satisfactory and that the RN/EN staff provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files (both hard copy and electronic) are protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation. Residents' files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC and ARHSS contracts. Exclusions from the service are included in the admission agreement. All long-term admission agreements (including the resident under ACC) and the one short-stay admission agreement for a respite care resident were signed and dated. All residents have been assessed by the needs assessment team prior to admission to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. All transfers to hospital use the yellow envelope system. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet guidelines. There is an electronic medication system in place. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation is completed by the RN on delivery of medication and any errors are</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>fed back to pharmacy. Registered nurses, enrolled nurses and senior caregivers who check and administer medications have been assessed for competency on an annual basis. Caregivers interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly.</p> <p>Standing orders are not used. There were no self-medicating residents on the day of the audit.</p> <p>Twenty medication charts (eight hospital, eight PG, three rest home including one respite and one serviced apartment) were reviewed on the electronic medication system. All medication charts reviewed have 'as needed' medications prescribed with an indication for use. The effectiveness of 'as required' medications are entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>CI</p>	<p>There is a current food control plan, which expires on 26 June 2019. All food and baking is prepared and cooked on-site. There are two head cooks supported by four assistant cooks, and two kitchen assistants. All staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with the company chef and the dietitian at organisational level.</p> <p>Project "delicious" is in place. 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 such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Cultural, religious and food allergies are accommodated. Special diets such as pureed/soft, diabetic desserts, vegetarian and gluten free are provided.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from daily resident contact, resident meetings, surveys and audits. Residents and relatives interviewed were complimentary of the menu and baking provided.</p> <p>There are nutritional snacks available in the PG unit 24 hours a day.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were</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.		no beds available or the service could not meet the assessed level of care.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the VCare system within 24-48 hours of admission for all residents entering the service including the respite resident. The myRyman electronic resident individualised care programme includes a number of assessments 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 calendars. InterRAI assessments had been completed for all long-term residents whose files were reviewed. Applicable VCare assessments are completed and reviewed at least six-monthly or when there is a change to residents' health/risk. The outcome of all assessments is reflected in the myRyman care plan. Behaviour assessments had been completed for the files of the four PG residents with the outcomes included in the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs, resident goals and provide detail to guide care. There was a behaviour management plan in the files of PG level care residents that included interventions and strategies for de-escalation including activities. MyRyman care plans are updated when there are changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, district nurse, wound care nurse and Mental Health Services for Older People. The care staff interviewed advised that the myRyman care plans were easy to access and follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate	FA	When residents condition changes the registered nurse initiates a GP or nurse specialist consultation. Registered nurse interviewed state that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to health of their

<p>and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>relative. Conversations and relative notifications are recorded in the electronic progress notes.</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.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are documented electronically, and wound monitoring occurs as planned in the sample of wounds reviewed.</p> <p>Two residents with chronic ulcers have had input from the GP wound care specialist and vascular team. There are currently six pressure injuries including two unstageable, one suspected deep tissue, one stage III, one stage II, and one stage I. The service has access to the wound care specialist team at the DHB, the Ryman clinical team and wound reps for advice and support. The wound care specialist and the GP has had involvement with the pressure injuries. The wound nurse champion for the facility reviews wounds regularly, and completes a monthly report. Photos of wounds demonstrate healing progress. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of five activities coordinators and a diversional therapist deliver the activities programme (Engage) across the rest home/ hospital, PG unit and serviced apartments. Activities are held seven days a week in the rest home/ hospital areas and the PG unit. The team is supported by a lifestyle manager at head office. Activity team attend on-site and organisational in-service relevant to their roles. All have current first aid certificates.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group. Rest home residents in the serviced apartments attend the serviced apartment programme. There are adequate resources available. Residents receive programmes in their rooms. Daily contact is made with residents who choose not to be involved in the activity programme. There is a men's group, a variety of speakers, a choir group and circuit training exercises.</p> <p>The rest home and hospital area also follow the Engage programme with extra activities such as food</p>

		<p>tasting, and pet therapy. There are additional individual activities such as nail cares, letter writing and chatting to residents on a one on one basis. There are twice weekly van outings.</p> <p>The PG unit have activities that are combined with the Engage programme and have more tactile sensory activities including lots of music and arts and crafts. There are van outings and walking groups. Both areas enjoy regular entertainers who visit and happy hour. Activities are available for caregivers to access around the clock. The activities care plans guide staff to activities and hobbies residents have enjoyed in the past.</p> <p>Facility activities and for celebrations and the like are held in the village garden with marquees in the summer.</p> <p>The facility has introduced lounge carers in the evenings on the PG and hospital areas, so residents have access to activities into the evening, and have supervision with supper.</p> <p>Regular interdenominational church services are held on-site.</p> <p>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 have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. Residents and relatives interviewed were happy with the range of activities on offer.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Seven of ten care plans had been evaluated by registered nurses' six-monthly. Two residents had not been at the service six months and the other resident was in for respite care. Written evaluations describe the resident's progress against the residents identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits. Care plan acknowledgment forms are signed by family six-monthly when care plans are reviewed.</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</p>	FA	<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 unit coordinators and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and other services as appropriate.</p>

and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<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 policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. 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 building has a current building warrant of fitness that expires 14 October 2019.</p> <p>The facility is divided into three floors with the special care unit (PG) on level one (ground), hospital on level two and serviced apartments on level three. There is a central reception area, a large communal lounge and dining room for apartment residents. Each unit in the care centre has a lounge and dining area with the hospital divided into two smaller areas, each with kitchen/server, dining and lounge areas. The PG unit has a secure garden area which is easily accessible and provides seating and shade.</p> <p>The maintenance person attends to any maintenance requests or call in contractors as required. There is a 12-monthly planned maintenance schedule in place. Electrical equipment has been tested and tagged. Hot water temperatures in resident areas are monitored monthly and within ranges.</p> <p>The hoist and scales are checked annually. The communal lounges and hallways are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>There is a gardening person responsible for the grounds and gardens.</p> <p>Residents were observed to access the outdoor areas safely.</p>
Standard 1.4.3: Toilet, Shower, And Bathing	FA	All rooms have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if

<p>Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>appropriate. There are privacy signs on all toilet doors. There are communal toilets situated close to the lounges.</p>
<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>	<p>FA</p>	<p>Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents are encouraged to personalise their bedrooms. Staff interviewed feel they have enough space to perform cares and for residents to move around freely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>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. There is a separate quiet area in the large open plan living/ dining area in the PG unit.</p> <p>Seating and space is arranged to allow both individual and group activities to occur.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in</p>	<p>FA</p>	<p>All laundry is done on-site. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was being attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaner's' trolley were labelled. There is a sluice room on each floor for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept locked when not</p>

<p>which the service is being provided.</p>		<p>in use.</p> <p>In March 2018 the facility commenced a laundry project. They installed a labelling machine and the purple bag system in order to reduce the number of unnamed/missing clothes items. This project has been evaluated and was noted as successful.</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>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The village has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, a sprinkler system and exit signs are in place. The service has an emergency generator on-site that is serviced by an external contractor. There are gas BBQs available in the event of a power failure and torches. There are three civil defence kits strategically placed around the facility. Adequate stores of drinkable water are on-site.</p> <p>Electronic call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. The service utilises internal cameras in the corridors in the PG unit to promote resident safety.</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>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. There is underfloor heating, with panel heaters in resident rooms which can be individually adjusted to resident's preference. Staff and residents interviewed stated that this is effective. There is a smoking area outside the building.</p>
<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</p>	<p>FA</p>	<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 registered nurse. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets on a two-monthly basis. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within the facility.</p>

service.		
<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) meet every two months. The infection control officer has been in the role for three years and completed an induction to the role and attended external infection control training and conference. The infection control officer collates infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections.</p> <p>The infection and prevention officer have 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 comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing 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 and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs. Infection control training was in April and May 2018.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are in place and appropriate to the complexity of the service provided. Individual infection reports are electronically recorded and a checklist for care is generated. The infection control officer (interviewed) collects monthly data and attends the two-monthly health and safety meetings. Staff are informed through facility meetings held at the facility. The infection prevention and control programme is linked with the teamRyman programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>In November 2017, there was a gastroenteritis outbreak. The outbreak was well managed with notifications sent in a timely manner. Staff were updated at each change of shift. There has been training in March 2018 around outbreak management.</p> <p>In August 2016, the service introduced measures to decrease the incidence of urinary tract infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. During the audit there were four residents (two PG unit and two hospital) with restraint (bedrails (1), chair briefs (3)) and two residents using enablers (bedrail (1), lap belt (1)).</p> <p>Assessment and consent processes were in place for both hospital level residents using enablers (bedrails and lap belt). Enabler use is monitored as per the monitoring schedule that is determined during the assessment process. The use of enablers is linked to the residents' care plan in myRyman.</p> <p>Staff training is provided at orientation and annually thereafter around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (unit coordinator PG/RN) 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>

policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessment and consents are completed in consultation and discussion with the resident/family/whānau and GP. Assessments are based on information in the initial care assessment, long-term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. Two resident files reviewed of residents with restraint included completed assessments that considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p> <p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a unit coordinator/registered nurse in the PG unit and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family, RN and restraint coordinator. The use of restraint is linked to the residents' care plans. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two residents' files where restraint was in use.</p> <p>Internal audits, conducted annually, measure staff compliance in following restraint procedures.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly as part of the ongoing reassessment for the residents on the restraint register, and six-monthly as part of the care plan review. Families are included as part of this review. Reviews were sighted in both files reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator, clinical services manager, GP and unit coordinator where the applicable resident(s) are located. Meeting minutes include (but are not limited to): a review of any residents using restraints or enablers; any

Services demonstrate the monitoring and quality review of their use of restraint.		updates to the restraint programme; staff education and training; and review.
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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
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The service identified a need to maintain resident’s enjoyment with the dining experience and satisfaction with the meals. A project was commenced in August 2016 to review the menu in consultation with the hospitality manager, head chef, management and residents.</p>	<p>Project delicious was introduced in 2016. The four-week rotating seasonal menu offers a variety of choices including three main dishes for the midday and two choices for evening meal including a vegetarian option. Gluten free meals are offered on the menu. Dietary needs are met through the project delicious menu options. The service has liaised with food suppliers to improve quality of suppliers including access to specialised pure foods for pureed options. As a result of the 2017 serviced apartments survey, the facility now provides free range protein for any special event. Other initiatives include an easy to read laminated menu card for ease of weekly ordering. There is a glossary on the back of each weekly menu card explaining the terminology of meals/desserts to assist the residents and staff when ordering meals. The dining rooms (viewed) have been set up to reflect an ambience of relaxed dining as observed during meal times.</p> <p>Evaluation of the project delicious menu and dining experience has been measured by, (i) feedback from residents at the resident meetings held around the project delicious meals. (ii) There have been no formal complaints around food since the introduction of project delicious, (iii) ongoing education for staff around food services, dining room etiquette, nutrition and hydration, (iv) interviews with ten residents and six relatives all stated the meals (choice, quality and presentation) were very good to excellent, (v)</p>

			residents are staying in the dining room longer once lunch has finished. The service has been successful in providing excellence in food services. The food satisfaction area of surveys show satisfaction has increased from 3.20 in 2017 to 3.64 in 2018.
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	<p>The service identified the laundry service as an area for improvement to reduce the amount of un-named clothing, with the view to reducing the lost clothing to zero.</p>	<p>The laundry project initiated in March 2018 aimed to reduce un-named clothes, improve the care of clothing (reduction of damage/ shrinkage), and to maintain tidy drawers and wardrobes in resident rooms. Each resident was provided with individually labelled laundry bags for their personal use. These labelled 'purple' bags were seen in residents' ensuites. The facility purchased a labelling machine and the laundry personnel label all residents' personal items on admission and as required. The laundry layout was improved to improve the flow and space for laundry staff to sort and fold laundry. Staff received training on the new machine and the laundry processes.</p> <p>The laundry person interviewed on the days of audit could describe the procedure for reducing the amount of un-named/missing clothing. There were four items of un-named/missing clothing on the days of audit, a reduction from in excess of 100 pieces at the start of the project.</p> <p>Residents and relatives were informed of the laundry procedures. Laundry audits have evidenced an improvement in laundry procedures. The service has been successful in reducing the amount of un-named/missing clothing with zero complaints in 2018.</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the</p>	CI	<p>Urine infections across the facility were identified as being consistently above the target range of 1.5/1000 bed nights.</p>	<p>The aim of the project was to reduce the rate of urinary tract infections (UTIs) in the PG and hospital units. The service introduced fluid assistants in the morning and evening lounge carers to assist residents with their fluid intake. A range of fluids are offered to residents including smoothies, ice blocks and choices of drinks. Jugs of drinks residents like to drink is delivered to resident rooms each day.</p> <p>The service liaised with the GP regarding the use of urinary catheters, and testing urine when clinically indicated. Education was provided around handwashing, use of continence products and continence management.</p> <p>UTIs feature prominently in clinical and staff meeting minutes.</p> <p>UTI graph shows UTIs have reduced across the facility and are below the target range of 1.5/1000 bed nights from May 2017 to July 2017. One resident was treated with two courses of antibiotics which was counted as two infections. UTIs have been consistently below the target range since April 2018 to date in the hospital unit. The infection control</p>

organisation.			officer reports there has been a reduction in the use of “probable UTI” diagnosis made and the use of antibiotics.
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End of the report.