

Jane Winstone Retirement Village Limited - Jane Winstone Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Jane Winstone Retirement Village Limited
Premises audited:	Jane Winstone Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 December 2019 End date: 3 December 2019
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:	64



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

Jane Winstone is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia level care for up to 89 residents. On the days of the audit there were 64 residents receiving care in the care centre and no residents at rest home level in the serviced apartments. The village manager (an ex-registered nurse) had been in the role seven weeks and supported by an assistant village manager and a clinical manager. The management team are supported by a regional manager and support staff at head office. The residents and relatives interviewed spoke positively about the care and support provided.

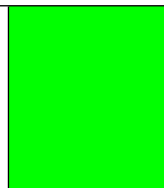
This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives,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

This audit identified areas of improvement required around interventions and implementation.

Continuous improvements were identified around the quality programme and infection surveillance.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

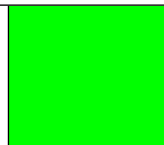


Standards applicable to this service fully attained.

The service complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

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 appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A 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 in place for new staff. Ongoing education and training are in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families reported 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

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

There is an information package for residents/relatives on admission to the service. The registered nurses' complete assessments, care plans and evaluations within the required timeframe. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner completes admission visits and reviews the residents at least three monthly.

The activity team provides an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The Engage programme meets the abilities and recreational needs of the groups of residents. The programme is varied and involves community visitors. There were individualised 24-hour activity plans for residents in the dementia care unit.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three monthly.

The project delicious menu is designed by a dietitian at an organisational level. All baking and meals are cooked on site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24-hours in the dementia care unit.

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 has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There was sufficient space to allow the movement of residents around the facility. The communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on site.

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. The service currently has six residents assessed as requiring the use of restraint and two residents using an enabler. The restraint coordinator maintains a register.

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.

All standards applicable to this service fully attained with some standards exceeded.

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. The service has had four outbreaks since the last audit.

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	47	0	1	1	0	0
Criteria	2	97	0	1	1	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>	<p>FA</p>	<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).</p> <p>Discussions with the village manager, assistant village manager, clinical manager/RN, operations quality manager, and 13 clinical staff (five caregivers who cover the rest home and hospital, three registered nurses (RNs), three unit coordinators, one activities coordinator and one diversional therapist) confirmed their familiarity with the Code. Non-clinical staff including; two laundry staff, one chef, one housekeeper and a maintenance person were also familiar with the Code.</p> <p>Interviews with seven residents (five rest home including; one respite resident and two hospital; including one funded through interim funding) and five relatives (two rest home, two hospital including one interim funding and one with a relative in the secure dementia unit) confirmed that the services being provided are in line with the Code. The Code is discussed at resident and staff meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	<p>FA</p>	<p>Informed consent processes are discussed with residents and families on admission. Written general consents are signed for by the resident or their enduring power of attorney (EPOA). Consents are signed for specific procedures such influenza vaccines and indwelling catheters. Advanced directives where available are kept in the resident files. Resuscitation status is made by the competent resident. There is evidence of discussion</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>with family when the GP completes a clinically indicated not for resuscitation order for residents deemed to be incompetent. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Two dementia care resident files identified the EPOA had been activated.</p> <p>Eight resident files reviewed (two dementia, three hospital including one resident for intermediate care and three rest home residents including one respite care) 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 they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks.</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. Visitors were observed coming and going during the audit. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, such as shopping. There is an on-site shop and hairdresser available. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<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 complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Sixteen complaints have been lodged in 2019 (year-to-date) including one complaint received via the Health and Disability advocate. Verbal and written complaints are documented.</p> <p>All complaints had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned. All complaints were documented as resolved.</p> <p>The complaint via the Health and Disability advocate included an investigation and a reply to the complainant as advised by the advocate. The complaint has been documented as closed by the service and the advocacy</p>

		<p>service.</p> <p>Complaints are linked to the quality and risk management system. The service has reviewed the complaints for trends, however there were no identifiable trends seen. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>An information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information around the Code had been provided to them. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager or the assistant village manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. 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 family members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. Staff have undertaken annual training on abuse and neglect during June 2019 with very good attendance.</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,</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. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with the district health board Māori health directorate. Cultural needs were addressed in the care plan of one resident who identified as Māori. Team meetings document cultural considerations including Māori language week in TeamRyman meetings.</p>

values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All residents at the facility were able to speak and understand English.</p>
<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. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries in respect of gifts.</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 policies 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>Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (eg, wound care, mental health) and staff education and training.</p> <p>The service has worked to improve services for residents and has implemented a number of quality programmes (link 1.2.3.6); these have included; i) Falls minimisation. This project included (but not limited to) education, medication review, physiotherapist input to mobilisation needs for at risk and frequent fallers and review of equipment. The outcome saw reducing rates of falls in the special care unit and falls remaining below the Ryman upper limit. ii) A project around reducing bruises and improving skin care to residents included; in-depth analysis of trends, a review of equipment and obtaining additional equipment as needed, staff education, discussion at staff meetings and working with staff around care plan interventions and best practice care</p>

		<p>provision. At the time of audit, bruises documented a downward trend and pressure injuries have remained below the Ryman limits (link 1.3.5.2 for care plan interventions).</p> <p>Jane Winstone identified that over the last six months the incidence of behaviours that challenge was higher than expected in the special care unit. A continuous improvement programme was commenced. The programme has resulted in a reduction in the incidences of behaviours that challenge (link 1.2.3.6).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Jane Winstone is a Ryman healthcare retirement village located in Whanganui. Jane Winstone provides rest home, hospital (including medical services) and dementia level care for up to 89 residents including 20 serviced apartments certified to be able to provide rest home level care. The care centre includes 39 dual service beds, 10 hospital level beds, and 20 dementia level beds. During the audit, the 20 serviced apartments included no rest home level residents. Occupancy in the care centre included; 30 rest home level residents including two respite and four funded through the intermediate care contract. There were 16 hospital level residents including; one funded though in the intermediate care contract. The dementia unit included 18 residents.</p> <p>The Ryman overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is a Ryman strategic and quality plan and a TeamRyman quality programme. There are documented quality/health and safety goals. The 'kindness culture' is a theme of the service philosophy.</p> <p>The village manager (previously a registered general and obstetric nurse in NZ and the UK) is currently working towards a postgraduate in healthcare ethics and has been in the role for seven weeks. The village manager is supported by a clinical manager (RN) and a non-clinical assistant manager. The operations quality manager from head office provides support and was also present at the audit.</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the assistant manager and clinical manager cover the manager's role. The assistant manager covers administrative functions and the clinical manager clinical care. The regional manager provides oversight and support. The service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<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>	<p>FA</p>	<p>The TeamRyman quality and risk management programme is fully implemented. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.</p> <p>All policies and procedures, and associated documents are created and regularly reviewed by the TeamRyman Programme committee. With the introduction of VCare Kiosk many of the clinical documents have been converted to an electronic format with triggers to stimulate compliance & centralised reporting to aid analysis of areas of weakness. The introduction of VCare Kiosk has driven a significant improvement in adherence to policies and procedures.</p> <p>The TeamRyman programme gives villages a monthly set of objectives and reporting requirements to ensure compliance to policies and procedures. The programme includes (but not limited to) internal audits, new policy releases or revisions, communication of objectives, reporting of statistics, etc. In addition, Ryman employs a team of internal auditors to spot audit sites.</p> <p>At service level, all data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are entered onto the electronic myRyman programme, collated and analysed with results communicated to staff and to head office. Corrective actions are implemented where benchmarked data exceeds targets.</p> <p>A fully implemented internal audit programme is in place. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented.</p> <p>Ryman's health and safety policies and procedures ensure a systemic review of all identified hazards including trend analysis to develop solutions that minimise risk. Safety is discussed by gardening and maintenance at huddles and at the beginning of each meeting.</p> <p>Strategies are implemented to reduce the number of falls. This includes but is not limited to ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and</p>

		intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.
<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. Unwitnessed falls did not always include neurological observations as per policy (link 1.3.6.1).</p> <p>A review of eleven incident/accident forms for the facility identified that all were fully completed and include timely follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify significant events that would be reported to statutory authorities, this has included a section 31 report for an externally acquired pressure injury.</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. Eleven staff files reviewed; (one clinical manager, five registered nurses, three caregivers, one activities coordinator, and one gardener) included a signed contract, job description, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals.</p> <p>A register of registered nurse's practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice.</p> <p>There is an implemented annual education plan. Each month the service is informed, via TeamRyman regarding what education is to be provided as well as any resources needed. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Six registered nurses and one enrolled nurse have completed their InterRAI training. Staff competencies are completed as relevant to the role. Registered nurses participate in two monthly RN/EN journal club which provides clinical updates and guidance. Coordinators are supported to attend the Ryman leadership training.</p> <p>There are 15 staff who work in the dementia unit, 13 have completed the dementia unit standards, two have</p>

		<p>recently completed and are waiting for their final assessment marks. Twelve staff have completed the dementia friend online course through Alzheimer's NZ.</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>The service staffing includes;</p> <p>A village manager who works Monday to Friday, an assistant village manager who works Monday to Friday and a clinical manager who works Sunday to Thursday. The clinical manager, assistant manager and village manager are in addition to the rostered staffing. There is a unit coordinator (RN) for the special care unit (dementia unit) who works Tuesdays to Saturdays and a unit coordinator for the serviced apartments Tuesday to Saturday. The unit coordinators are included as part of the rosters.</p> <p>The special care unit (18 residents) on the day of audit, staffing included;</p> <p>Two staff members for the AM (this includes a unit coordinator or an RN), two staff members for the PM (both caregivers, one is medication competent) and two caregivers at night. Day staffing also included a lounge caregiver 4 pm to 8 pm seven days a week and designated activity staff seven days a week.</p> <p>Staffing for the rest home/hospital wing included;</p> <p>Registered nurses who provide oversight for all of the care centre are rostered one RN each shift seven days a week plus an additional RN 9 am to 1 pm Tuesday to Saturday.</p> <p>Caregivers for the hospital/rest home;</p> <p>There are 26 residents, all at rest home level; AM one full shift and two short shifts, PM two full shifts and a short shift and one on nights.</p> <p>Caregivers for the Hospital wing;</p> <p>There are 20 residents (16 at hospital level and four rest home); AM two full shifts and two shorter shifts, PM one full shift and two shorter shifts and one on nights.</p> <p>It was reported that all staff help each other across wings.</p> <p>On the days of audit, staff on duty were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team 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>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident's individual record within 24 hours of entry. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files were protected from unauthorised access. Entries were dated and included relevant caregiver or registered nurse, including designation. The electronic system (myRyman) demonstrated service integration of resident records.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services, including an admission policy. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack outlines the services and levels of care provided including specific information for families of relatives admitted to the dementia unit. Relatives interviewed stated they were well informed upon admission.</p> <p>The admission agreement reviewed for six long-term residents aligned with the service's contracts. The respite care resident had a short-term agreement in place. The hospital level care resident under intermediate care had needs assessment approval.</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>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that complies with Ministry of Health medication guidelines. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver competencies. Regular and 'as required' medications are delivered in blister packs which are checked by an RN against the medication charts. The blister packs are signed on the back following reconciliation and any errors are fed back to pharmacy. Medications are stored safely in the care centre and the dementia care unit. Caregivers and RNs interviewed were able to describe their role in regard to medicine administration. A caregiver observed on a medication round (dementia care unit) followed correct procedures. Education around safe medication administration has been provided. Medication fridges were monitored weekly and temperatures</p>

<p>guidelines.</p>		<p>were within acceptable limits. The service has commenced medication room temperatures which evidence they do not exceed 25 degrees. All eye drops, ointments and sprays were dated on opening. All medications were prescribed for the resident and no bulk supply order was held on site. There were three self-medicating residents (two rest home and one hospital level) with self-medication competencies signed by the GP. Medication was stored safely in the resident's rooms.</p> <p>Fifteen electronic medication charts (six hospital, five rest home and four dementia care) and one paper-based medication chart (respite care) were reviewed and evidenced that all medication documentation has been completed appropriately including charting and administration signing. The effectiveness of 'as required' medications is recorded in progress notes and in the electronic medication system. All medication charts (including the paper-based chart) had photo identification and the allergy status recorded.</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>FA</p>	<p>All food and baking are prepared and cooked on site. The newly appointed qualified lead chef is supported by cooks, morning and afternoon kitchen assistants. Staff have been trained in food safety and chemical safety. Project-delicious has been implemented with an improvement in meals. The four weekly seasonal menu is reviewed regularly by a dietitian at organisational level. The menu offers three choices for the midday main meal and two meal options for the evening meal as well as a vegetarian and gluten free option. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Special diets such as pureed/soft diets are provided. Resident dislikes and dietary preferences were known and accommodated. Nutritious snacks are available 24 hours in the dementia unit. Meals are delivered in hot boxes and served from bain maries in the unit kitchenettes and serviced apartments.</p> <p>There is a current food control plan which expires 9 May 2020. Freezer/chiller temperatures, end-cooked temperatures, cooling and inward chilled goods temperatures are taken and recorded daily. All foods in the pantry were date labelled. All perishable foods in refrigerators were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, surveys and direct contact with the chef. Residents interviewed commented there had been an improvement on the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reason for declining entry to the service would be if there were no beds available or if the service could not meet the assessed needs for the potential resident.</p>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The facility has embedded the interRAI assessments within its clinical practice. InterRAI assessments and assessment summaries were evident in the files reviewed. Initial assessments including relevant risk assessments (falls, behaviour, pressure injury) have been completed on admission. Long-term care plans are reviewed six monthly as part of the evaluation process. Additional assessments were completed according to need. The outcomes of all assessments, needs and supports required, were reflected in the care plans (link 1.3.5.2).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	MyRyman care plans reviewed were overall resident-centred and included medical information, activities of daily living, categories of care with support needs and interventions to meet the resident goals, however there was a shortfall around supports for residents at risk of pressure injury. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. Care plans included the involvement of allied health professionals in the care of residents.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	<p>When a resident's condition alters, a registered nurse initiates a review and if required, a GP visit or nurse specialist consultant. Interventions required were documented in the resident's care plan, however not all changes to care had been identified and interventions implemented. Residents interviewed stated their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place (on the electronic database) for 17 wounds (ulcers, skin tears and lesions and one pressure injury). Scheduled change of dressings and evaluations had been completed. There was one resident with a non-facility acquired suspected deep tissue injury on the day of audit. A section 31 had been completed. Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse as required. The GP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans (link 1.3.5.2).</p> <p>Continence products are available and resident files included urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist</p>

		<p>continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms are in place to monitor a resident's progress against interventions implemented for changes to health. Neurological observations had not been completed as per protocol where required. Progress notes document changes in health and significant events.</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>	FA	<p>There is a team of activities staff (two diversional therapists, an activity assistant and van driver) who coordinate and implement the Engage programme across the care centre and the dementia care unit. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, walking groups, sensational senses, make and create, reminiscing, themes events and celebrations, baking and cooking, games, entertainment, outings and drives.</p> <p>Activities are provided Monday to Sunday until 6 pm in the special care unit (link CI 1.2.3.6) and Monday to Friday in the care centre. An evening lounge carer in the care centre also offers a range of activities. Caregivers in the dementia care unit incorporate activities and one-on-one time with residents as part of their role. Two afternoons a week is allocated to spend one-on-one time with care centre residents who choose to stay in their rooms and not participate in group activities. There are regular outings/drives for all residents as appropriate (weekly for dementia residents), weekly entertainment and involvement in community events. On site church services are held in the facility chapel. Community visitors include volunteers, village residents, entertainers and canine pet therapy.</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. Behaviour management plans for dementia care residents included de-escalation and redirection through the use of individual one-on-one time and activities. 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. There has been an increase in resident/relative satisfaction survey results from 3.88 in 2018 to 4.21 in 2019. Residents and relatives interviewed commented positively on the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>Long-term care plans reviewed had been evaluated by registered nurses for long-term residents who had been at the service six months. One hospital intermediate care resident had a long-term care plan in place but did not require an evaluation. One rest home resident was on respite care. Written evaluations for long-term residents describe the resident's progress against the resident's identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager and activities staff. Input is sought from caregivers and other allied health professionals involved in the care of the resident. The GP reviews the residents at least three monthly. Family are invited to the MDT review and notified of the</p>

manner.		outcome/changes if unable to attend. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Referral to other health and disability services is evident in the group of 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 reassessed for a higher level of care such as intermediate care to rest home level of care and from respite care to dementia care. Discussion with the RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.
<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	There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are dispensed through a mixing system. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets and a spills kit were available. Relevant staff have completed chemical safety training.
<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</p>	FA	The building has a current building warrant of fitness that expires 17 March 2020. The facility employs a maintenance manager who oversees the maintenance and grounds team of staff across the village and care centre. The property manager from head office visits the site at least six monthly and is readily available by phone. Requests for repairs is logged into an internal maintenance book which is checked frequently throughout the day and signed off as repairs are completed. There is a planned maintenance schedule which includes internal and external building maintenance and equipment checks. Electrical testing is completed annually. Hot water temperatures in resident areas are monitored three monthly as part of the environmental audits. Temperature recordings reviewed were below 45 degrees Celsius. Contractors are available 24 hours

<p>purpose.</p>		<p>for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the gardens and grounds with seating and shade provided.</p> <p>The dementia care unit is located on the ground floor with doors that open out onto secure gardens with walking pathways. Seating and shade is provided.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>Since the previous audit the following improvements have been made; All rest home and special care (two residents remain on their own beds) beds replaced with electronic beds and pressure relieving mattresses. The service has also purchased an Arjohuntleigh Hoist and a further air pressure mattress. There has been a refurb of 'Nurses Hub' and computer surfaces in resident's rooms for quick access to care plans and documentation</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All bedrooms are single occupancy and have ensuites. There were communal toilets located closely to the communal areas with privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</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</p>	<p>FA</p>	<p>All residents' rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>

setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The care centre has a separate dining room for the rest home and hospital residents. There is a large lounge with seating placed to allow for individual or group activities. There is a smaller lounge/library area and seating alcoves throughout the facility. The serviced apartments have a dining area, lounge and library room. All the communal areas are easily accessible. There is an on-site chapel, hairdressing salon and shop.</p> <p>The dementia care unit has a spacious open plan dining/lounge area with seating placed appropriately to allow for low stimulus, small group and individual activities. The communal areas were easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on site. The laundry operates from 9 am to 3 pm and from 7 pm to 10 pm. The laundry has an entry and exit door and clean/dirty defined areas within the laundry. Cleaners trolleys were well equipped and stored in a locked cleaners' cupboard when not in use. The laundry and cleaning service are monitored by internal audits and resident feedback. The chemical provider monitors the effectiveness of chemicals. Residents interviewed stated they were happy with the cleanliness of their bedrooms. Residents stated they were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster policies in place to guide staff in managing emergencies and disasters. Emergency management and fire evacuations drills are included in the mandatory in-service programme. A non-fire emergency training was held to prepare staff in the event of a disaster. There is a first aid trained staff member on every shift. The village has an approved fire evacuation plan and fire drills occur six monthly, last in November 2019. There are sufficient supplies of food, water and equipment for at least three days. The service has a generator.</p> <p>There is an effective call bell system in all bedrooms, ensuites and communal areas. The call bells and door alarms are linked to pagers carried by staff. Calls light up on the main call panel in the nurse's station. The call points in the dementia unit are specifically designed to disguise the emergency button.</p> <p>The facility is secure after hours. There is secure entry and exit to the dementia care unit.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external</p>

<p>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>windows with plenty of natural sunlight.</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 service.</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. There is an infection prevention and control responsibility policy that included a chain of responsibility and an infection prevention and control coordinator's job description. The infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet bi-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the TeamRyman calendar. The facility had developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. An appointed registered nurse is responsible for infection prevention and control at the facility. She has been in the role for three weeks and is supported by the clinical manager.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator is new to the role, and the clinical manager has maintained best practice by attending infection control updates. The infection control team is representative of the facility. Resident care plans reviewed included comprehensive documentation for any known infections. An example is one resident with shingles. The care plan described required interventions and staff demonstrated good knowledge of the care needed for this resident.</p> <p>External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	<p>FA</p>	<p>There were comprehensive infection prevention and control policies that were 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 templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>

<p>accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. The resident meetings for October document clear instruction regarding avoiding urinary tract infections and the importance of drinking. May and June meetings discussed cough etiquette.</p>
<p>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.</p>	CI	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator who is a registered nurse. The registered nurse is directly responsible to the clinical manager.</p> <p>An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the bi-monthly infection prevention and control (IPC) meetings. All meetings held at Jane Winstone include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation.</p> <p>There have been four outbreaks at the facility since the last audit. All were gastroenteritis outbreaks; one was confirmed as norovirus. All were reported and managed well. The laundry person interviewed was very knowledgeable regarding cross infection and laundry needs for infectious linen. The service has reduced the incidence of urinary tract infections following a robust action plan.</p>
<p>Standard 2.1.1: Restraint</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were two residents using an enabler (bedrail) and six residents with restraints during the audit. Both the resident files were reviewed where an enabler (bedrails) was in use. Voluntary consent and an assessment process had been completed. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is a registered nurse with a job description that defines the role and responsibility of the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The approval group meets six monthly and all restraint and enablers are reported to TeamRyman monthly.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, approval group, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two residents' files with restraint use (chair briefs) were reviewed. Completed assessments considered those listed in in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialed before</p>

safely		<p>implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator/approval group. The use of restraint and risks identified with the use of restraint was linked to the two resident care plans reviewed, however the risk associated with restraint were not well documented (1.3.5.2). Internal audits conducted, measure staff compliance in following restraint procedures. 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>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>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three 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 in the review of restraint use. Files reviewed for residents with restraint use evidenced that evaluations were up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator and members of the approval group. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme, and staff education and training and review.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	MyRyman care plans are readily available to all staff and cover medical information, activities and supports for daily activities of living. Care plans lacked detail around pressure injury prevention for residents assessed at high risk of pressure injury and for two residents on chair brief restraint.	i) There were no documented pressure injury interventions for two hospital and one dementia resident who had been assessed at high risk of pressure injury. One hospital resident had a non-facility acquired pressure injury and the other hospital resident had a previous sacral split now healed (and is on chair brief restraint) and ii) two residents on chair brief restraint (one hospital and one dementia care) who had been assessed at high risk of pressure injury did not have pressure injury identified as a risk associated with the use of restraint.	i)and ii) Ensure pressure injury prevention supports and interventions included in care plans for residents identified at risk of developing pressure injuries.

				60 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Monitoring charts included (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Neurological observations are required to be completed post unwitnessed falls or where there is an identified head injury or knock to the head. Not all interventions had been implemented for change to health.</p>	<p>Monitoring charts included (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Neurological observations are required to be completed post unwitnessed falls or where there is an identified head injury or knock to the head. Not all interventions had been implemented for change to health.</p> <p>i) Neurological observations had not been completed for six of six falls reviewed where neurological observations were required, ii) there were no interventions in place for one hospital resident (under intermediate care) with unintentional weight loss and iii) there was no re-positioning chart in place for the last week for one hospital resident with a suspected deep tissue pressure injury of heel.</p>	<p>Ensure interventions are implemented and documented to monitor resident health changes.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	During September to November 2018, the service noted that the incidences of behaviours that challenge were higher than the Ryman trend and the incidences showed an increasing trend. A plan was implemented, aimed at reducing the incidence of behaviours that challenge. Behaviour instances per 1000 bed days are monitored and reported at monthly quality meetings.	The service increased the focus on incidents involving behaviours that challenge. All incidents related to behaviour were (and continue to be) discussed at the daily ‘clinical huddle’ and handovers. Additional education was provided around prevention and management of behaviours that challenge including engaging the psychogeriatric team from the DHB to provide education. The GP provided assistance with the nursing and psychogeriatric team and reviewed all medications as needed. The activity team reviewed and implemented changes to the activity plan. The nursing care plans were also reviewed and updated to reflect a person-centred approach to behaviour management. As a result of the plan and the changes, the challenging behaviour incidents in the special care unit reduced from 71 for 1000 bed days during the month of November 2018 to 6.55 March 2019. The trend has continued down with 1.06 incidents per 1000 bed days for November 2019.

<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Infection control statistics are generated monthly and are reviewed by the infection control nurse; reports are provided to the two monthly infection control meetings, clinical meetings, and monthly myRyman meetings. The meetings noted a high incidence of urinary tract infections (UTIs) April 2019. A plan was implemented to address the high incidence of urinary tract infections.</p>	<p>Following discussion at the infection control meetings and myRyman meetings the service developed an action plan to reduce the incidence of urinary tract infections. The plan included; education for staff specific to UTI prevention, education for staff around infection control and hand washing and education for residents and family (as evidenced through relative and family meeting minutes). Residents were offered increased fluids, ice blocks and smoothies. Each lounge had jugs of flavoured drinks always available to residents (and this was viewed on the day of audit). The service reviewed clinical practice and handovers were used to remind staff of the importance of continence care toileting and the need for fluids for residents.</p> <p>UTI rates reduced and continued a downward trend, with zero UTIs reported August to November 2019.</p>
--	-----------	--	--

End of the report.