

Bob Owens Retirement Village Limited - Bob Owens 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:	Bob Owens Retirement Village Limited
Premises audited:	Bob Owens 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: 9 February 2016 End date: 10 February 2016
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:	117



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

Bob Owens is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 150 residents. On the days of the audit, there were 117 residents. A village manager, an assistant village manager and a clinical manager manage the service. 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, family, management, staff and a general practitioner.

One area of improvement required was identified around general practitioner (GP) review of medications. An area of continuous improvement was identified around laundry services.

Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established 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. Examples of good practice were provided.

There is an established system for the management of complaints, which meets timeframes established by the Health and Disability Commissioner.

Organisational management

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

Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, 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 quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is 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 report that staffing levels are adequate to meet the needs of the residents.

The integrated resident 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Residents and relatives receive a comprehensive package on admission regarding services provided at the facility. The registered nurses complete assessments, care plan development and evaluations within the required timeframe. Monitoring forms were being utilised. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status.

The activity team provides an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community. There were 24-hour activity plans for residents in the dementia care unit that were individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. Medication is appropriately stored, managed, administered and documented.

All meals are prepared on site. A dietitian designs the menu at an organisational level. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food 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.

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

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 hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There is an approved fire evacuation plan and emergency policies and procedures in place. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The restraint coordinator maintains a register. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

There were four residents using enablers and two hospital residents with restraints during the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. The infection prevention and control officer is a registered nurse who has completed infection control education. Staff receive annual infection control training. Policies and procedures reflect best practice including definitions for surveillance. Monthly infection events are collated and forwarded to head office for analysis and organisational benchmarking. The results of surveillance are used to identify infection control quality initiatives and education requirements. There have been no outbreaks within the last year.

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	48	0	1	0	0	0
Criteria	1	99	0	1	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 Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with nine care assistants (CAs) who work across each area and am and pm shifts, and four registered nurses confirmed their understanding of the Code. Ten residents (seven rest home level and three hospital level) and five relatives (three dementia level, one hospital level, one rest home level) interviewed confirmed that staff respect privacy, and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completes a clinically indicated not for resuscitation order. Care assistants and registered nurses (RN) 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.</p> <p>All eleven resident files sampled (three dementia, four rest home and four hospital) have a signed admission agreement and consents.</p>

and give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	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. 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. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed (nine caregivers, four activities staff, four registered nurses and one education officer) were able to describe the process around reporting complaints. A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). There is evidence of complaints received being discussed in the applicable meetings. All complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed	FA	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. Large print posters of the Code and advocacy information are displayed throughout the

<p>of their rights.</p>		<p>facility. A 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>	<p>FA</p>	<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. An annual resident satisfaction survey was completed in February 2015 and the results showed that the vast majority of respondents reported overall resident experience as being good or very good. 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 included family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with CAs described how choice is incorporated into resident cares.</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>	<p>FA</p>	<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 disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of 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 recognise and</p>	<p>FA</p>	<p>An initial care-planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly team Ryman (full facility) meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers, registered nurses and CAs confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 around their policies. A range of clinical indicator data is collected against each service level. The data is reported through to head office for collating, monitoring and benchmarking between facilities. Feedback is provided to staff via the various meetings as determined by the Team Ryman Programme. Quality Improvement Plans (QIP) are developed where results do not meet targets. VCare is the electronic patient system used by all sites to report relevant data through to head office. A number of quality initiatives have been implemented around improving physiotherapy input into the care of residents who are at risk of falling, reducing the number of call bells not answered within a target timeframe, and creating a welcoming and structured orientation process for new staff to ensure they feel welcomed, supported, confident and competent in their roles.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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 enter details into VCare. 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>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>Bob Owens is a Ryman Healthcare Retirement Village located in Bethlehem, Tauranga. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. It provides rest home, hospital and dementia level care for up to 150 residents. This includes 30 serviced apartments certified to be able to provide rest home level care, 40 rest home level beds, 40 hospital level beds and 40 dementia level beds. Occupancy during the audit was 42 rest home level residents (including three in the serviced apartments), 39 hospital level residents and 36 dementia level residents. All residents were on the Aged Related Care Contract.</p> <p>There is a documented service philosophy set at head office that guides quality improvement and risk management in the service. Specific objectives have been determined for the facility. Organisational objectives for 2015 reflected regular reviews and reporting to head office on progress towards meeting these objectives. Goals for 2016 were in draft format.</p> <p>The village manager has been in the role for 10 months and has previous experience managing legislative and assurance audits for the Waikato District Health Board. An assistant manager who carries out administrative functions and an experienced clinical services manager (registered nurse) who oversees clinical care support him. The wider Ryman management team that includes a regional manager supports the management team.</p> <p>The village manager has maintained at least eight hours of professional development activities related to managing a retirement village.</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>The clinical manager/registered nurse covers the village manager's role in his absence, with additional support provided by the regional manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>Bob Owens has a well-established quality and risk management system that is directed by head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the managers (village manager, regional manager, clinical manager/RN, clinical audit and practice manager), the GP, and staff (nine CAs, four RNs, one health and safety officer, one chef, four activities</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>coordinators, one cleaner, two laundry staff, one maintenance staff, one education coordinator), and review of a range of meeting minutes demonstrated staff involvement in quality and risk activities.</p> <p>Resident meetings are two monthly and relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed annually. Quality improvement plans (QIPs) are completed with evidence that areas identified as requiring improvements are addressed.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly Team Ryman programme calendar. Policies are communicated to staff, evidenced in staff meeting minutes. Updates to policies included procedures around the implementation of InterRAI.</p> <p>The quality-monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings. A health and safety officer is appointed who has completed 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. Ryman has achieved tertiary level ACC Workplace Safety Management Practice to March 2016.</p> <p>Falls prevention strategies are in place. Initiatives implemented include routine checks of all residents specific to each resident's needs (intentional rounding), regular physiotherapy input for all residents who are at risk of falling, attendance at activities and exercise programmes, the use of sensor mats, night light sensors and staff awareness of residents who are at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, 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>A review of 13 incident/accident forms (five falls, five bruises, three pressure injuries) identified that forms are fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>event process.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities including infectious diseases; serious accidents; unexpected death; and specific situations to HealthCERT.</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>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (six CAs, five registered nurses, one chef, one activities coordinator) included a signed contract, job description, police checks, induction, application form and reference checks. Staff files reviewed also included annual performance appraisals.</p> <p>A register of registered nurse and other health practitioner practising certificates is maintained.</p> <p>An orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are provided with written training information if they are unable to attend the in-service.</p> <p>Registered nurses are supported to maintain their professional competency. A monthly journal club is established. Five registered nurses have completed their InterRAI training. There are implemented competencies for registered nurses and CAs related to specialised procedures or treatments, including medication competencies and insulin competencies.</p> <p>A total of 31 CAs work in the dementia unit and 19 have completed the required dementia standards. The remaining twelve CAs have been employed for less than one year with seven enrolled and five employed in the unit for less than six months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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. There is a minimum of one RN and seven CAs on site at any time. Activities are provided seven days a week in the hospital and dementia units.</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. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing</p>

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack for residents being admitted to the secure dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy.</p> <p>The admission agreement reviewed aligns with the service's contracts. Eleven admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</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. A transfer form accompanies residents to receiving facilities and communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication is stored and administered in accordance with current legislation and guidelines. All medication fridges are temperature checked weekly and corrective actions documented where temperatures are outside the required range. On delivery of medication, an RN completes medication reconciliation and any errors fed back to pharmacy. As required (PRN) medication expiry dates are checked monthly. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training. Standing orders are not used. There were no self-medicating residents on the day of audit.</p> <p>Twenty-two medication charts and signing sheets were reviewed (eight rest home [including two from the</p>

		<p>serviced apartments] and eight hospital and six dementia care).</p> <p>The medication profiles reviewed were legible and up to date. Medications are prescribed by the GP and medication charts met legislative requirements. Not all medication charts had been reviewed at least three monthly by the GP.</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>	FA	<p>The service employs a qualified head chef who is supported by a weekend cook and kitchen staff on the morning and afternoon shifts. All staff have been trained in food safety and chemical safety. A four weekly seasonal menu had been designed and reviewed by a dietitian, at organisational level. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly reviews and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes, food allergies and dietary preferences were known. Alternative foods are offered. Special diets such as pureed/soft meals, diabetic desserts, and gluten free are provided. Nutritious snacks and 'food on the run' platters are delivered to dementia care and available 24 hours. Food is delivered in hot boxes to each area and served from bain-maries. Residents with special meal requirements have their meals plated and labelled. The serving temperature in the bain-maries are monitored and recorded daily. Fridge and freezer temperatures are checked twice daily. Chilled goods temperature is checked on delivery. Food temperatures are monitored twice daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident and staff meetings, surveys and audits. The head chef has regular contact with residents and receives feedback on the meals.</p> <p>Kitchen staff have completed food safety and chemical management training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The right to appeal against assessment outcome policy states the manager at every stage, will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau and referring agency.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The facility has embedded the InterRAI assessment protocols within its current documentation. InterRAI assessments have been utilised for new admissions and for changes in levels of care. All other residents are scheduled for an InterRAI assessment one week prior to their six monthly evaluations for 2016. Additional assessments for management of behaviour, and wound care were appropriately completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans reviewed were resident centred and support needs were documented as identified through the ongoing assessment process. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect acute changes in health status and were evaluated six monthly at the MDT review. There was evidence of service integration with documented input from a range of allied health professionals and specialists.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Communication with the GPs for residents' change in health status was sighted in the resident's files.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds, (14 skin tears, one chronic ulcer, 12 other minor wounds, one pilonidal sinus). There was one hospital level resident with a hospital acquired grade 2 pressure injury of both heels and one dementia level if care resident with a facility acquired grade 2 pressure injury of the heel.</p> <p>Pressure area prevention strategies are included in the long-term care plans for all residents identified as high risk of pressure injury. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management from the Ryman wound care nurse specialist.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to) weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts as needed.</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>The activity team consisting of four activities coordinators are in the process of completing their diversional therapy training (DT). The two activity coordinators in the dementia units are qualified caregivers with the dementia units.</p> <p>The team implement a separate activity programme for the rest home, hospital and dementia areas. The Ryman 'Engage' programme is delivered Monday to Friday in the rest home and hospital and seven days a week in the dementia care unit. There is an activity coordinator for each of the two dementia care units. The Engage programme provides activities that are meaningful and relevant for all cognitive capacities and are gender appropriate. Some of the activities such as entertainment and church services are integrated for all residents. One on one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There are regular outings/drives for all residents (as appropriate) and involvement in community groups including floral society, conservation projects, library, canine friends and charities.</p> <p>The resident/family/whānau as appropriate, complete a life experience form on admission and are involved in the development of the activity plan. A record is kept of individual residents activities. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. Resident meetings are held bi-monthly and are open to families to attend.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses six monthly or when changes to care occurred. Care plans for short-term needs are used for infection events and are evaluated and signed off when resolved. The MDT review involves the RN, GP, activities staff, resident/family and other health professionals involved in the residents care. The family are notified of the outcome of the review by phone and if unable to attend receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the MDT care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated,</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. 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. Discussion with the clinical manager and two unit coordinators identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.</p>

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 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 were labelled correctly and stored safely throughout the facility. Safety data sheets were available. Staff handling chemicals have attended chemical safety training.</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 12 May 2016. The maintenance manager oversees the maintenance team responsible for the reactive and 12 monthly planned maintenance schedule. There are contractors available 24 hours for essential services. Electrical testing and tagging, hoist servicing and calibration of clinical equipment is completed annually.</p> <p>Hot water temperatures in resident areas are monitored and temperatures recorded were within the acceptable range.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards and the indoor atrium. Seating and shade is provided.</p> <p>Each 20-bed dementia unit (located on the third level) has a safe, secure outdoor balcony area with seating, shade and raised gardens.</p> <p>The care assistants and RNs stated they have sufficient equipment to safely deliver resident cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided</p>	FA	<p>All bedrooms are single occupancy and have ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>

<p>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>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>All residents' rooms were of an appropriate size to allow cares to be provided for the assessed level of care. There is sufficient space for staff to manoeuvre mobility aids and hoists. Residents are encouraged to personalise their bedrooms.</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 unit has an open plan lounge and dining area. There are separate spacious lounge areas and a dining room in the hospital and rest home areas. There are smaller quiet lounge/library rooms in both areas. The communal areas were easily accessible for residents.</p> <p>There is a large open plan lounge and dining area in the dementia care units and a separate family/quiet room in each unit. Furniture was appropriately placed to allow for individual and group activities.</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</p>	<p>CI</p>	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the Team Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas. There are multiple areas for storing cleaning equipment.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is</p>

<p>service is being provided.</p>		<p>laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner. The service has been awarded a continuous improvement rating for laundry services. .</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 first aid trained staff member on every shift and during outings. The village has an approved fire evacuation plan. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Gas barbeques and torches are available in the event of a power failure. Emergency lighting is in place, which is regularly tested. A civil defence kit is in place. Supplies of stored drinkable and non-drinkable water are held on site. Electronic call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. Residents in the rest home, hospital and serviced apartments were observed during the audit to be in close proximity to their call bells. Calls bells are also readily available in communal areas. Security staff are employed from dusk to dawn, seven days a week. The service utilises security cameras 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>General living areas and resident rooms are appropriately heated and ventilated. There is under floor heating and electric wall heaters in the rest home area only. All rooms have external windows with plenty of natural sunlight. The site is smoke free.</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</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control programme is linked into the quality management system via the Team Ryman programme and is reviewed on an annual basis. The infection prevention and control committee has combined meetings with the health and safety committee that meets bimonthly. The facility and clinical meetings include a discussion of infection prevention and control as evidenced in meeting minutes. An appointed registered nurse is responsible for infection prevention and control at the facility and has a job description that defines responsibilities of the role. She has been in the role for two months.</p> <p>Visitors are asked not visit if they are unwell. Residents and staff are offered influenza vaccinations.</p>

and scope of the 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 control officer holds a recognised qualification through Waiariki polytechnic (2011) and has recently completed the on-line Ministry of Health course. The infection prevention and control committee is made up of a cross section of staff from areas of the service. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, internal expertise from within the organisation and an external infection control consultant. The facility has established links with the GPs, local laboratory, the infection control and public health departments at the local DHB.</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 reflect 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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support</p>	FA	<p>The infection prevention and control officer 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 cares.</p>

staff, and consumers.		
<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>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are in place appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and kept as part of the resident files. Infections were included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff were informed through the variety of meetings held at the facility. The infection prevention and control programme is linked with the Team Ryman 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/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks within the last year.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were four residents using enablers and two hospital residents with restraints during the audit. One resident file was reviewed where an enabler (wheelchair lap belt) was in use. Voluntary consent and an assessment process were 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</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (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>

process is made known to service providers and others.		
<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, 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. One hospital-level resident's file where restraint was in place was reviewed. The completed assessment 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 safely</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 trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents' care plans. Internal restraint audits 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 one resident file where restraint (bedrails) was being used.</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 in conjunction with the six-monthly care plan review. Families are included as part of this review. A review of one resident file identified that evaluations are up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality</p>	FA	<p>Restraints are discussed and reviewed at the six-monthly restraint meetings. These meetings are attended by the restraint coordinator, clinical manager, GP and unit coordinator where the applicable resident(s) are located. 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>

review of their use of restraint.		
-----------------------------------	--	--

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Medication charts met legislative prescribing requirements. All medication charts reviewed have 'as required' medications prescribed with an individualised indication for use. All medication charts had photo identification and allergy status. Five of 16 medication charts had not been reviewed at least three monthly by the GP.	Four of eight rest home medication charts and one of six dementia unit medication charts did not evidence three monthly reviews by the GP.	<p>Ensure all medication charts are reviewed by the GP at least three monthly.</p> <p>90 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
<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 implemented a laundry labelling system with a staff member allocated time to name all clothing as sorted from the purple personal clothing bags. Staff were educated in the use of the labelling machine. Residents and relatives were advised of the labelling process on admission. Internal audits were completed to ensure compliance of laundry processes. Photographic evidence of lost property before and after the implementation of the project demonstrated the service has been successful in reducing the amount of lost property. Feedback on the laundry service via resident and relative surveys (September 2015) noted a decrease in lost laundry and all laundry was labelled.</p>	<p>The service identified an improvement required around reducing the amount of unclaimed clothing. The February 2015 relative/resident survey results demonstrated there was dissatisfaction with the laundry service around missing clothing. The service implemented a laundry labelling system with a staff member allocated time to name all clothing as sorted from the purple personal clothing bags. Staff were educated in the use of the labelling machine. Residents and relatives were advised of the labelling process on admission. Internal audits were completed to ensure compliance of laundry processes. Photographic evidence of lost property before and after the implementation of the project demonstrated the service has been successful in reducing the amount of lost property. Feedback on the laundry service via resident and relative surveys (September 2015) noted a decrease in lost laundry and all laundry was labelled.</p>

End of the report.