# Bruce McLaren Retirement Village Limited

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bruce McLaren Retirement Village Limited

**Premises audited:** Bruce McLaren Retirement Village Limited

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 28 September 2015 End date: 29 September 2015

**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:** 107

# 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 |
|  | 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

Bruce McLaren Retirement Village is a Ryman Healthcare facility. The facility provides rest home, hospital level and dementia level of care for up to 158 residents. On the day of audit there were 107 residents (including two in serviced apartments). The village manager is suitably qualified, and supported by a clinical manager (registered nurse) and an assistant village manager. There are systems in place that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme.

The audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with relatives, residents, staff, management and the general practitioner. Residents and relatives spoke positively about the services and care provided at Bruce McLaren facility.

Areas identified for improvement are aspects of care planning and medication management.

## 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 that adhere with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (ie, the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori Health plan in place. Individual care plans reference the cultural needs of residents. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. There is an established system in place for the management of consumer complaints.

## Organisational management

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

Ryman Healthcare Ltd head office staff provide governance and operational support to the facility. They ensure that the services provided at the village are planned and coordinated to meet the needs of residents and that staffing is maintained at an appropriate level to meet residents’ needs. The village manager, who is overseen by a regional manager, has been in the position since August 2014. A clinical manager, who is a registered nurse, supports the village manager. There is an established quality and risk management system in place that is overseen by head office and is outlined in the Ryman Accreditation Programme (RAP), which includes monitoring of resident satisfaction including complaints management, internal auditing, adverse clinical events, infections, and health and safety events. The performance of the village is benchmarked to other Ryman facilities. Performance is reported at facility meetings. There are policies and procedures in place for human resources management. Staff in-service education sessions are provided and staff are supported to attend external education, as appropriate. Individual education records for staff are maintained. There is a policy for determining staffing and skill mix for safe service delivery. The village is using a range of software to support clinical documentation. Clinical care is recorded electronically.

## 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. |

There was comprehensive service information available. The registered nurse completed initial assessments and risk assessment tools on admission. InterRAI assessments are in use for all new admissions and six monthly reviews. Care plans and evaluations were completed within the required timeframe by the registered nurses. Care plans entered into the electronic system demonstrated service integration, were individualised and evaluated six monthly. Copies of care plans were available for care staff. The residents and family interviewed confirmed they were involved in the care planning process and invited to the three monthly reviews with the general practitioner.

The activity coordinators and diversional therapists provide a separate activities programme for rest home, hospital and dementia care residents. The Engage programme ensures the individual abilities and recreational needs of the resident are met. The programme is varied, interesting and involves the families and community.

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

Meals are prepared on site. The menu has been designed by a dietitian at organisational level. Individual and special dietary needs were catered for and alternatives are provided. There are additional snacks available 24 hours in the dementia units.

## 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 certificate for public use. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. Emergency management systems and processes are in place. All bedrooms have ensuites. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is completed 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. |

There were comprehensive policies and procedures that meet the restraint standards. There is a restraint coordinator with delegated responsibilities. Enabler and/or restraint use is discussed at approval committee and clinical meetings. There was ongoing restraint and challenging behaviour education evident. There were no residents requiring enablers or restraint at the time of 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 clinical manager manages the infection prevention and control programme. The infection prevention and control team holds 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 no outbreaks since the previous 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** | 0 | 43 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with six healthcare assistants (HCAs) who work across the care centre and one from the serviced apartments, four registered nurses, and one enrolled nurse coordinator in the serviced apartments demonstrated an understanding of the Code. Residents interviewed (six rest home and five hospital) and relatives (four dementia care and one hospital level) confirmed that staff respect privacy and support residents in making choice where able. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents (as appropriate) and families on admission. Written general consents are obtained during the admission process. Consents for specific procedures were sighted for influenza vaccine and indwelling catheter.  Staff interviewed confirmed consent is obtained when delivering cares. Resuscitation orders for competent residents were appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident was deemed incompetent to make a decision.  Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. Eleven admission agreements (four rest home, four hospital and three dementia care residents) sighted, were signed within the required timeframe. |
| 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 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 sampled 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. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents were 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. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a documented complaints management procedure in place. The organisational complaints policy was being implemented. The village manager has overall responsibility for ensuring all complaints are fully documented and investigated. A complaints register is maintained that includes relevant information. Documentation was available to support the seven resident complaints received since opening. The number of complaints received each month was reported monthly to staff via the various meetings. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Feedback forms were available for residents/relatives in various places around the facility. A complaints procedure was provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is an information pack 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 through the facility. The 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. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were 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.  The service had a philosophy that promoted quality of life and involved residents in decisions about their care. Resident preferences were identified during the admission and care planning process and this included family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.  Healthcare assistants interviewed described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. 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. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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 further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Residents and family are invited to attend. Discussion with relatives confirmed that residents’ values and beliefs are considered. Residents interviewed confirmed that staff take into account their culture and values. |
| 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 full facility 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 two managers, registered nurses and healthcare assistants confirmed an awareness of professional boundaries. Healthcare assistants could discuss professional boundaries in respect of gifts. |
| 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 on their policies.  A range of clinical indicator data are collected against each the service level, and 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 Ryman Accreditation Programme (RAP). Quality Improvement Plans (QIP) are developed where results do not meet expectations. The system of data analysis and trend reporting is designed to inform staff at facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.  Bruce McLaren has implemented two good practice initiatives since they opened the level-one dual-purpose beds last December, related to restraint minimisation and the management of residents with challenging behaviours.  The facility has adopted a restraint free policy. On the day of audit, none of the 44 rest home or 37 hospital level residents were using restraints or enablers. Clinical staff have successfully utilised alternative approaches to restraint management across all three areas. The clinical manager states their approach has involved more creative thinking by staff and its application has not caused in an increase in resident falls. Ryman has installed electronic movement sensors in each bedroom in the specialist dementia unit, which can be individually tailored to meet each resident’s needs. Sensor mats and cameras in the corridors provide additional observational tools.  The dementia units opened in February 2015. Management and staff from the dementia unit have maintained close working linkages with staff from the Mental Health Services for Older Persons (MHSOP) team, Counties Manukau DHB that began prior to opening. Currently staff meet fortnightly with the team coordinator MHSOP, the Ministry of Health Northern region behavioural support and advisory coordinator, a psychiatric district nurse from MHSOP and a consultant psychiatrist from MHSOP. These liaison meetings are enabling active management of residents within the dementia unit. Although occupancy has steadily increased since February 2015, the number of challenging behaviour incidents within the dementia unit has decreased from 9.2 incidents per thousand bed days in May to 1.8 incidents per thousand bed days, in the seven months to August 2015. |
| 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 within the electronic database. Family are notified and this action is recorded in the resident’s progress notes. Staff are required to record family notification when entering an incident into the system. Incidents reviewed for the month of August 2015 met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The governing body, Ryman Healthcare Limited, has established systems in place that define the purpose, values, scope, direction and goals of the organisation and the facility, and the monitoring and reporting processes against these systems. The service provides rest home, dementia care and hospital level care for up to 158 residents in a three level building. There are 43 rest home/dual purpose beds on level 1, plus 30 rest home approved beds in serviced apartments, 44 hospital level beds (which are located on level 2), and 41 dementia level beds in two separate units (one 21 bed and one 20 bed unit) on level 3.  There were 107 residents in the facility on the day of audit including 46 rest home level residents (of which two were living in rest home approved serviced apartments), 37 hospital level residents (including two respite cares) and 24 residents receiving specialist dementia services (including two respite cares). There are no residents under contracts other than respite or the Aged Residential Care contract.  Ryman Healthcare has an organisational total quality management plan in place. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the Ryman Accreditation Programme (RAP).  The village manager commenced employment in August 2014. He has previous health management experience and supported by a clinical manager who is a registered nurse with a current practising certificate, who has been in the role since July 2014. The clinical manager was previously employed in health management and has psychiatric nursing experience. The village manager, in consultation with the clinical manager, leads daily operation of the village. Each area has its own dedicated coordinator except for the rest home, as the position is currently vacant. In the interim, the hospital coordinator is overseeing care in the rest home area on level one and the clinical manager is overseeing the care in the hospital area on level two where her office is located. Coordinators, who are registered nurses, manage the rest home, hospital and a coordinator, who is an enrolled nurse, manages the dementia care unit and the serviced apartments.  The management team is supported by the wider Ryman management team, which includes support from a regional manager.  The village manager and clinical manager have maintained at least eight hours to date of professional development activities related to managing a village. |
| Standard 1.2.2: Service Management  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. | FA | If the village manager is absent for an extended period, then the village is managed by the clinical manager with assistance from the assistant manager. Depending on the circumstances, Ryman may appoint a temporary relief village manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service is implementing the Ryman Accreditation Programme (RAP), which links key components of the quality management system to village operations. Staff interviewed understood the quality programme. The onsite RAP committee meets monthly. Outcomes from the RAP Committee are reported across the various meetings including the full facility, registered nurse and healthcare assistants meetings and minutes are displayed in the staff room. Meeting minutes include discussion about the key components of the quality programme.  Policy reviews are coordinated by Ryman head office. These occur at least three yearly in line with the document control policy. Facility staff have the opportunity to provide feedback during the review process. Policy documents have been developed in line with current best and/or evidenced based practice. Policies are available on the intranet. Facility staff are informed of changes/updates to policy at the various staff meetings.  The RAP prescribes the annual internal audit schedule that was being implemented. Audit summaries and quality improvement plans are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee (eg, RAP, health and safety).  Monthly clinical indicator data are collated across the all areas. There is evidence of trending of clinical data and development of quality improvement plans when results do not meet expectations. The quality system includes the monitoring of adverse events, consumer complaints, infection prevention and control, health and safety and restraint management. The combined health and safety and infection prevention and control committee met bimonthly and include discussion of all incidents/accidents and infections. There was a current hazard register in place. Management reports progress to head office staff at least monthly, against the quality and risk management plan, and quality improvement initiatives. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | All adverse events are documented and reported to head office. Events are recorded directly into the electronic systems and in the resident’s progress notes. All adverse events for the month of August 2015 were reviewed. Monthly analysis of incidents by type was undertaken by the service and reported to the various staff meetings. Data was linked to the organisation's benchmarking programme and used for comparative purposes. Quality improvements plans (QIPs) were created when the number of adverse events exceed expectations. QIPs were seen to have been actioned and closed out. Senior management are aware of the requirement to notify relevant authorities in relation to essential notifications. There has been no need to notify any external agencies of any adverse events. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Head office staff oversee human resource practice, with the village manager managing most of the onsite requirements with support from the clinical manager and assistant manager. There are organisational policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the staff files reviewed. A register of practising certificates is maintained. Performance appraisals are current in all files reviewed. Staff interviewed spoke positively about their orientation, induction and ongoing access to educational opportunities.  Competency, training and management of key personnel who have commenced duties following the provisional audit was reviewed. Thirteen employment records were reviewed.  There was an annual training plan in place, which was aligned with the RAP and is being implemented.  Ryman ensures its registered nurses (RN) are supported to maintain their professional competency. An RN journal club meets two monthly. Ryman has a 'Duty Leadership' training initiative that all registered and enrolled nurses and senior leaders complete. There was an induction programme being implemented with completion being monitored and reported monthly to head office as part of the RAP programme. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre (which includes rest home, dementia and hospital level services), is overseen by a fulltime clinical manager. Interviews with healthcare assistants regarding the roster operated in each area, confirmed that there areas were staffed in keeping with industry and contractual standards. Staffing of HCAs in the dual-purpose area on level one is matched to meet the acuity needs of the resident mix. The same situation occurs for hospital and dementia level residents. Staffing in the dementia units is being increased in a staged approach as occupancy increases.  HCAs interviewed reported there are sufficient staff on duty at all times and this was confirmed by observation from the audit team over both days. The serviced apartments have their own dedicated staffing. Interviews with residents and relatives also indicated there are sufficient staff to meet resident needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard in both areas or on the electronic patient management system. Care plans and notes were legible and where necessary signed (and dated) by staff including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The clinical manager screens all potential residents prior to entry to services, to confirm they meet the level of care provided at the facility. Eleven residents and five relatives confirmed they received information prior to admission and discussed the admission process and admission agreement with the clinical manager or village manager. Currently there is a waiting list for rest home and hospital level beds.  The admission agreement aligns with the ARC contract requirements. There is specific admission information for families with relatives entering the dementia care unit. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Transfer information is completed by the registered nurse or clinical manager and is communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. RNs interviewed could describe the required transfer documentation. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | RNs, enrolled nurses and healthcare assistants responsible for the administering of medication complete annual medication competencies and attend annual medication education. Medications are checked on delivery, against the medication chart. Medication trolley contents were all within expiry dates and all eye drops were dated on opening. There were five residents who self-medicate with completed self-medication assessments, which are reviewed by the GP three monthly. Standing orders are not in use. Medication administration practice was observed to be compliant however, one inhaler had not been administered as prescribed (link rest home tracer). Twenty-two medication charts sampled met legislative prescribing requirements and had photo identification and allergy status identified.  Twenty-two medication charts reviewed identified three monthly medication reviews signed by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service employs a qualified chef manager, cooks assistant and kitchen assistant daily, to prepare and provide all meals on-site. A four weekly seasonal menu had been designed and reviewed by a dietitian at organisational level, in November 2014. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes. Soft/pureed and diabetic desserts and alternative foods for known dislikes are provided. Food is delivered in hot boxes to each kitchenette and served from bain-maries by healthcare assistants. Staff were observed sitting with the residents and assisting them with meals. Staff interviewed state there are nutritious snacks available 24 hours in the dementia care units. Adequate snacks were sighted in the kitchenette fridge and cupboards.  The kitchen is well equipped. The chiller temperature is checked twice daily. Fridge and freezer temperatures are checked and recorded daily in the main kitchen and kitchenettes. End cooked food temperatures are monitored. All foods were date labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals were stored safely in the kitchen.  Staff have been trained in safe food handling and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled demonstrate that personal needs information is gathered during admission.  Risk assessment tools were sighted as completed on the electronic system and reviewed at least six monthly or when there was a change to a resident’s health condition. InterRAI assessments include identified risks, with interventions included in the long-term care plans. Resident files sampled demonstrated that care plans reflected the outcome of the risk assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | An initial support plan is completed within 24 hours in consultation with the resident (as appropriate) and relative. Nine of eleven long-term care plans sampled reflected the resident’s current health status. Resident files sampled evidenced that resident/family involvement in the care planning process was documented. Residents and relatives interviewed confirmed they were involved in their care plans. Resident files evidenced allied health input into residents care.  Behaviour management plans were sighted in the three dementia care resident files sampled. The plans were individualised and included triggers for identified behaviours, interventions and activities over the 24-hour period. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents and relatives interviewed reported that resident’s needs were being met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultation.  Dressing supplies are available and treatment rooms adequately stocked for use. Wound assessment, wound treatment and evaluations, including frequency for 18 skin tears and 8 minor wounds were entered on the electronic system. There were no current pressure areas. Residents identified as high risk of pressure areas had interventions documented in the long-term care plan. The RNs interviewed have access to a company wound nurse who visits weekly to review all wounds.  The GP reviews the wounds three monthly or earlier if required.  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 was described by the clinical manager and the RNs interviewed.  Behaviour monitoring forms are used to monitor challenging behaviours. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A team of activity coordinators and two diversional therapists (DT) implement separate activity programmes for the rest home, hospital and dementia care units. They are supported by a Ryman occupational therapist that meets regularly with the team and oversees the programmes. The Engage programme is delivered Monday to Sunday in the hospital and dementia care units and Monday to Friday in the rest home. Resources are available for care staff to use at any time for activities in the weekends.  There are choices of activities for rest home (including rest home residents in serviced apartments) and hospital residents to attend. The DTs ensure all residents are aware of the activities available and assist them in attending activities of their choice. Regular contact is made and one on one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. Each unit (including dementia care) has a walking group and residents are taken for supervised walks/wheelchair walks in the grounds and gardens at least twice daily (weather permitting) or around the facility. Residents were observed to be engaged in the activities provided throughout the facility on the day of audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The evaluation and care plan review policy require that care plans are reviewed at least six monthly. Six of eleven resident files had written evaluations that described progress against each goal and need identified in the care plan (sighted in resident files). Five residents (two rest home, two hospital and one dementia care resident) had not been at the service six months. Family are invited to attend the multidisciplinary team (MDR) review meetings. The physiotherapist, GP, activity coordinator, RN and healthcare assistants are involved in MDR meetings. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. Discussions with registered nurses and the clinical manager identified that the service has access to allied health professionals and specialists.  The service provided examples of where a resident’s condition had changed and the resident reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | 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 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 are available. Relevant staff have attended chemical safety training. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current certificate for public use issued 14 July 2015. The service is a three level building with stair and lift access.  The head maintenance person addresses daily maintenance requests and preventative maintenance. Hot water temperatures in resident areas are monitored and stable between 43-45 degrees Celsius.  The grounds and gardens are landscaped and well maintained. There is safe access to the outdoor gardens and courtyards on the ground level. Hospital level residents are supervised and regularly access the outdoors and have a deck area on the second level, which is safe to access.  The healthcare assistants and RNs interviewed state they have sufficient equipment to deliver the cares safely, as outlined in the resident care plans.  Each dementia unit has an open courtyard with easy access. All outdoor areas have seating and shade available. There is sufficient space for residents to wander safely and freely indoors and outdoors.  On the day of audit, the two dementia units were not being managed totally separately due to occupancy below 25 residents. On the day of audit, there were 21 of 21 residents in one dementia unit and only three of 20 residents occupying the other 20-bed unit. During the daytime hours the three residents from the 20 bed unit were being cared for with the other 21 residents. Management advised that the units would be separated once combined occupancy reached 25 residents in the specialist dementia units.  There was sufficient space within the dementia units to permit freedom of movement while promoting the safety of residents who are likely to wander. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | All bedrooms in the units have ensuites. There were communal toilets located closely to the communal areas. Toilets have appropriate signage and privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each unit has a lounge and dining area. There were seating alcoves and family rooms available for quiet private time or visitors. The communal areas were easily and safely accessible for residents.  There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits were completed as per the RAP programme. The laundry had an entry and exit door with defined clean/dirty areas. The service had a secure area for the storage of cleaning and laundry chemicals. Material safety data sheets and personal protective clothing was readily accessible in the laundry and sluice rooms.  There are dedicated cleaning and laundry persons on duty each day. 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. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The Village has an approved fire evacuation scheme dated 10 November 2014. There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and cardiopulmonary resuscitation (CPR) are included in the mandatory in-service programme. There was a first aid trained staff member on every shift. Fire drills take place six-monthly. Smoke alarms, a sprinkler system and exit signs are in place. The service has alternative cooking facilities available in the event of a power failure and Ryman has an arrangement in place for supply of an emergency generator. Emergency lighting is in place, which will last for four hours. There are civil defence kits in the facility and stored drinkable and non-drinkable water on site. Electronic call bells are evident in residents’ rooms, lounge areas, and toilets/bathrooms. The facility is secure at night and external security is in place. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated with underfloor heating. There is adequate ventilation. All rooms, bedrooms and communal areas have external windows with plenty of natural sunlight. |
| Standard 3.1: Infection control management  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. | FA | 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 officer’s job description. The infection prevention and control programme is linked into the quality management system via the RAP. The infection prevention and control committee combined with the health and safety committee, meets 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 RAP annual calendar. The facility had developed links with the GPs, local laboratory, the infection control and public health staff at the local DHB. Staff advise visitors who are sick not to enter the premises. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control committee (combined with the health and safety committee), is made up of a cross section of staff from areas of the service. The facility also has access to infection prevention and control nurse specialists, public health specialists, GPs and expertise from within the organisation. |
| Standard 3.3: Policies and procedures  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. | FA | There are comprehensive infection prevention and control policies that are current and reflected in the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman. The infection prevention and control policies link to other documentation and cross reference where appropriate. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection prevention and control officer is responsible for coordinating and providing education and training to staff. The infection prevention and control officer (ie, the clinical manager) has appropriate training for the role. The 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections are in place and appropriate to the complexity of the service provided. Individual infection reports are recorded electronically and reports can be run to list all infections in any given month. Monthly data is reported to the combined infection prevention and control and the health and safety meetings. Staff are informed through a variety of meetings held at the facility. The infection prevention and control programme is linked with the RAP. The infection prevention and control officer used the information obtained through surveillance, to determine infection prevention and control activities, resources and education needs within the facility. There is close liaison with the GPs that advise and provide feedback to the service. There have been no outbreaks of infection since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service was restraint free at the time of audit. There were no enablers in use.  The restraint coordinator (clinical manager) attends six monthly Ryman restraint approval committee meetings. The use of enablers/restraint is discussed at clinical meetings and RAP meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  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. | PA Low | There were no signing gaps in 21 of 22 medication signing sheets. ‘As required’ medications had the time and date of administration recorded on the singing sheet. Dietary supplements had been administered as prescribed. One rest home resident stated they did not receive their inhaler as prescribed. | One rest home resident was prescribed an inhaler three times a day. The signing sheet did not evidence the inhaler was administered consistently three times a day. | Ensure medications are administered as prescribed.  60 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 Low | Long-term care plans for nine out of eleven residents files sampled were up to date and reflected the resident’s current needs. Care plans are updated as needs change. | The long-term care plans for two residents did not reflect the resident current health status as follows: 1) Rest home resident with a medical diagnosis of diabetes (as per GP notes), did not have diabetes and diabetic management identified in the long-term care plan. 2) Hospital resident long-term care plan had not been updated to reflect current supports and interventions regarding healed pressure areas and weighing frequency. | Ensure long-term care plans reflect the resident’s current health status.  60 days |

# 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.

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End of the report.