# Possum Bourne Retirement Village Limited - Possum Bourne 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](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:** Possum Bourne Retirement Village Limited

**Premises audited:** Possum Bourne 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: 6 July 2017 End date: 7 July 2017

**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:** 94

# 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

Possum Bourne is part of the Ryman Group of retirement villages and aged care facilities and has been operating for ten months. The service provides rest home, hospital and dementia level of care for up to 120 residents in the care centre and rest home level of care for up to 30 residents in serviced apartments. On the day of audit there were 94 residents. There were no rest home residents in the serviced apartments. The service is managed by an experienced village manager and clinical manager/registered nurse. Both are supported by regional manager and other experienced personnel at head office. The residents and relatives interviewed spoke positively about the care and support provided.

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

An area for improvement was identified around the initial interRAI assessment.

## 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 (HDC) Code of Health and Disability Services Consumers’ Rights (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. 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 can visit residents at times that meet their needs. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments. Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

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

There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme which is varied and interesting for each resident group. The engage programme meets the abilities and recreational needs of the group of residents including outings.

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

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours.

## 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 certificate for public use. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuite. There are adequate numbers of communal toilets. There is 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 are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. There were no residents with restraint or an enabler at the time of the audit. Staff receive training around restraint minimisation.

## 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. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. There have been no outbreaks in the care centre.

## 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 | 44 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 92 | 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](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 Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information related to the Code is made available to residents and their families. Four managers (one village manager, one assistant to the manager, one clinical manager, one regional manager) and twelve care staff (three registered nurses (RNs); six caregivers (two rest home, two hospital and two dementia care) and three activities staff) described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme. |
| 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 and families on admission. Written general consents reviewed in ten resident files (four hospital including one respite resident, one resident under chronic medical illness and one resident under ACC, four rest home and two dementia care) were signed by the resident or their enduring power of attorney (EPOA).  Advanced directives and/or resuscitation status are signed for separately by the competent resident/GP. Ten of ten files were viewed. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative’s lives.  Eight resident files of long-term residents have signed admission agreements. The respite care resident has signed a short-term agreement. The other file was for a resident under ACC funding. |
| 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/enduring power of attorney (EPOA) to be involved in decisions. The residents’ files include information on the resident’s 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. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Residents are encouraged to integrate into village activities such as health and art expos. 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 organisational complaints policy is being implemented at Possum Bourne. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and operations manager (RN) are involved in clinical complaints. The facility has an up-to-date on-line complaint register. Concerns and complaints are discussed at relevant meetings. One verbal and five written complaints have been made to date for 2017. Follow-up letters, investigation and outcome had been documented. One written complaint has been received by the DHB via Worksafe. Some aspects were found to be partially substantiated. The provider completed internal investigations and corrective actions have been implemented and monitored. There has been no further action required. Interviews with residents and relatives confirmed they were provided with information on the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Five relatives (two rest home, one hospital and two dementia care) and eight residents (five rest home and three hospital) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager, assistant to the manager and clinical manger reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives 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 | Ryman policies that support resident privacy and confidentiality are being implemented at Possum Bourne. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents’ privacy by knocking on doors prior to entering resident rooms and ensuring doors were closed while care was being undertaken. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents’ preferences including cultural, religious, social and ethnic are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into resident cares. There are policies, procedures and training in place around elder abuse and neglect. |
| 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 have been established with the local iwi and both parties meet annually. Other community representative groups are available as requested by the resident/family. There were no residents who identified as Māori at the time of the audit. |
| 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 family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged 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. |
| 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 provide guidelines and mentoring for specific situations. Interviews with staff 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 range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. 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 expectations or non-conformances are identified. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. |
| 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 and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Incident forms viewed (fifteen) evidence the family have been informed of accident/incidents. Relatives interviewed stated that they are informed when their family members health status changes. Relative meetings commenced February 2017 in each of the units (rest home, hospital and dementia care). The service produces a monthly newsletter “Possums Post” that is readily available to all residents, relatives and visitors to the facility. The information pack and admission agreement included payment for items not included in the services. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is 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 | Possum Bourne is a Ryman Healthcare retirement village providing rest home, hospital and dementia level care for up to 122 residents in the care centre. The facility has been operating 10 months and is also certified to provide rest home level of care in 30 serviced apartments.  The facility has four levels with care beds located on three floors. The second level has the two 20-bed dementia care units and serviced apartments, the third level has 41 rest home beds (certified as dual-purpose) and serviced apartments and the fourth level 41 hospital beds (certified as dual-purpose). On the day of audit, there were 94 residents (41 at rest home level of care with one resident in the hospital unit, 28 hospital level of care and 25 at dementia level of care – 19 residents in one unit and nine in the other unit). There were no rest home residents in serviced apartments. On the day of audit there was one hospital level respite care, one hospital resident under the long-term chronic health condition (medical services) and one hospital resident funded by ACC. All other residents were under the ARCC.  Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. Possum Bourne has village objectives for 2016 that have been reviewed and new objectives set for 2017. Progress against the village objectives were last reviewed April 2017. Evidence in staff and management meeting minutes reflect discussions around the 2017 objectives.  The village manager (non-clinical) at Possum Bourne has been in the role at another Ryman facility for two years before commencing as village manager at Possum Bourne in July 2016. He is supported by an assistant to the manager (non-clinical), who carries out administrative functions and an experienced clinical manager (appointed August 2016) who oversees the clinical care across the facility.  The clinical manager is supported by a unit coordinator in each area. The management team is also supported by the Ryman management team including a regional manager and regional quality coordinator. The regional manager was present on the days of the audit. The village manager and clinical manager have both completed specific manager orientation with Ryman and attend relevant teleconferences. The village manager has attended the annual Ryman two-day conference which included leadership, strategic planning, future planning and technology. |
| 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 | The clinical manager (RN) will fulfil the manager’s role during a temporary absence of the village manager with support from the regional manager and Ryman management team. |
| 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 | Possum Bourne has established their quality and risk management system since opening that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team (village manager, assistant to the manager and clinical manager) and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities. Meetings have been held as scheduled and evidence discussion around quality data including the outcomes of survey, internal audits, concerns/complaints, infection control and accident/incidents.  Annual resident surveys have been completed in February 2017 and a relative survey was completed in March 2017. Results were fed back to participants. Quality improvements were raised for identified areas of improvement.  The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. These are communicated to staff, as evidenced in staff meeting minutes and sighted on the staff noticeboards.  The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems including policies and procedures are developed, implemented and regularly reviewed. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. There is an internal audit schedule that is monitored by head office. Quality improvements plans are raised for any non-compliance. Results are communicated to staff across a variety of meetings and reflect actions being implemented and completed.  Falls prevention strategies are in place that include, hi/lo beds, ongoing falls assessment and exercises by the physiotherapist, floor sensor mats, bed sensor mats and motion sensor lights in the dementia unit, appropriate footwear and falls prevention education.  Health and safety policies are implemented and monitored by the two-monthly combined health and safety and infection control meetings. The village manager has overall responsibility for the health and safety across the service and completed stage-one of the health and safety training. A health and safety representative has recently been elected and has completed stage-one of the health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. The hazard register for generic and specific hazards was introduced August 2016. All staff completed a comprehensive health and safety induction on orientation to the new facility and all new staff attend health and safety inductions. Contractors are required to complete site safety inductions. |
| 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 | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of fifteen incident/accident forms from across all areas of the service, identified that all are fully completed and include follow up by a RN. The clinical manager is involved in the adverse event process, with links to the applicable meetings (team Ryman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur. The village manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. There have been five Section 31 notification for pressure injuries. No coroner’s notifications have been required. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (one clinical manager, one serviced apartment unit coordinator, two registered nurses, one assistant to the manager, four caregivers, one activities coordinator and one kitchen assistant) provided evidence of signed contracts, job descriptions relevant to the staff members role and reference checks. A register of RN and enrolled nurse (EN) practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.  An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Thirteen caregivers work in the dementia unit. Three of the 13 caregivers have completed their dementia qualification. Ten caregivers are progressing through their dementia unit standards. Three of the 10 caregivers have been employed less than six months.  Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Health practitioners and competencies policy outlines the requirements for validating professional competencies. There are currently 15 RNs working at Possum Bourne. Six RNs (including the clinical manager) have completed interRAI training. InterRAI trained RNs are seconded from another Ryman facility to complete interRAI assessments as required. |
| 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 village manager and clinical manager, work full time Monday to Friday and are on call 24/7. Each service unit in the care centre has a RN unit coordinator on five days a week. The serviced apartment has an enrolled nurse coordinator. Interviews with caregivers informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are sufficient staff to meet resident needs.  Staffing at Possum Bourne is as follows:  In the rest home unit on the morning shift: there is one RN and four caregivers (two on full shifts and two on short shifts), afternoon shift - four caregivers (two on full shifts and two on short shifts and on night shift: two caregivers.  In the hospital on the morning shift: there is a unit coordinator, five days a week and another RN. There are five caregivers on full morning shift and two on short shifts; afternoon shift: there are two RNs, three caregivers on full shifts and two on short shifts and on night shift: one RN and three caregivers.  In the dementia units, there is one unit coordinator or RN on morning shifts across the two units (shared office between the two units). In unit one (19 residents), there are two caregivers on full shifts and one on short shift. There is an RN and two caregivers on full shifts and one on short shift on the afternoons. Night shift there are two caregivers across the two units. In unit two (9 residents), there is a caregiver per shift with support from another caregiver from unit one. The RNs in the hospital oversee the dementia unit and the rest home on the night shifts.  Staffing in the serviced apartments (currently no rest home residents) includes a serviced apartment coordinator (EN), two caregivers on mornings (one full shift and one short shift), and one senior caregiver until 9pm and covered from the rest home from 9pm to 7am. There is currently no rest home residents in serviced apartments. |
| 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 within 24 hours of entry into the resident’s individual record. 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 caregiver or registered nurse 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 | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.  Information gathered on admission is retained in residents’ records. The 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 admission agreement reviewed aligns with the service’s contracts for long-term and short-term care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with ministry of health medication requirements. Medication reconciliation is completed by the RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications are stored safely in all the units. Medication fridges are monitored daily. Expiry dates of medications are checked weekly. All eye drops were dated on opening.  Standing orders are not used. There were four rest home residents who had been assessed as competent to self-administer inhalers/sprays by the RN and GP.  Twenty medication charts (seven rest home, eight hospital, including one respite (paper based medication chart) and five dementia care) medication charts were reviewed on the electronic medication system. All medication charts reviewed have ‘as needed’ medications prescribed with an indication for use. The effectiveness of ‘as required’ medications is entered into the electronic medication system. |
| 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 | All food and baking is prepared and cooked on-site. The two qualified chefs are supported by three cook assistants and four kitchen assistants. All staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with company chef and the dietitian at organisational level. Menu sheets are completed for individual residents for the week ahead. The menu offers two choices including a vegetarian dish. Meals are plated in the main kitchen and delivered to the units in hot boxes. There are snacks available over 24 hours in the dementia unit.  The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft, diabetic desserts and gluten free are provided.  Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received through direct feedback, resident meetings, surveys and audits. |
| 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 reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that were triggered were reflected in the care plans reviewed. Additional assessments such as behavioural, wound and restraints were completed according to need. Assessed needs and supports required were described in care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed demonstrated service integration and input from allied health.  Resident care plans were resident-centred and support needs and interventions were documented to reflect the resident goals.  Family members interviewed confirm care delivery and support by staff is consistent with their expectations.  Residents (if appropriate) and family stated they were involved in the care planning and review process. Behaviour management including triggers, interventions and successful de-escalation techniques was included in the long-term care plan in two of the two dementia care resident files. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. The family members interviewed stated their relative’s needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant.  Wound assessments, treatment and evaluations were in place for skin tears, two chronic ulcers, a surgical wound, two lesions and seven pressure injuries. The Ryman wound nurse specialist visits fortnightly and is readily available for advice. Adequate dressing supplies were sighted in the treatment rooms.  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.  Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events. |
| 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 | There are three activities coordinators, one for each unit, who have completed some qualifications and working towards their diversional therapy qualification, (e.g., the rest home coordinator holds the national aged care certificate, has undertaken the Triple A exercise certificate and is progressing through the diversional therapy (DT) course). They coordinate and implement the Engage programme. A Monday to Friday programme is delivered in each unit and on the weekend if there is a special event.  The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group such as Triple A exercises. There are adequate resources available. Residents receive programmes in their rooms. Daily contact is made with residents who choose not to be involved in the activity programme. Special events and theme days are celebrated. Ryman head office provides the activities coordinators with a programme of what is to be included in the activities programme including exercise, intellectual, creative and craft and religious activities (the facility has a chapel). The facility writes the programme and has it approved by head office. Residents may attend activities organised in the village including residents in the dementia care unit who can attend facility activities as appropriate and under supervision. Residents in the dementia unit have a 24 hour resident specific activities plan. The dementia unit has an attractive and secure outdoor area for residents to use.  Activity assessments are completed for residents on admission. The activity plan is reviewed with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through weekly ‘huddles’ with the activities coordinators, monthly meetings with the manager and satisfaction surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Eight of ten care plans had been evaluated by registered nurses six monthly. Two residents had not been at the service six months (one rest home) and one resident was for respite care. Written evaluations describe the resident’s progress against the resident’s identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits. |
| 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 | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident’s condition had changed and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice, MHSOP and contracted allied services (dietitian, physiotherapist and podiatrist). |
| 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 were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. 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 certificate for public use that expires 3 August 2018. The facility employs a full-time maintenance person who has been involved in the construction of the building. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule which has been signed as completed (sighted). Essential contractors are available 24 hours. Electrical testing and annual calibration is not yet due as all equipment was purchased new less than one year ago. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.  The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.  The dementia units on the second floor, due to the lay of the land, have a spacious, secure outdoor areas with lawn, gardens, outdoor seating and a walking pathway.  The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| 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 rest home, hospital and dementia units are single occupancy and have full ensuites. Fittings and fixtures are made of easy clean surfaces that meet infection control practice. There are communal toilets located close to the communal areas. Toilets have 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 | All resident’s rooms were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. 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 | The dementia care unit, rest home and hospital units have a main lounge and family lounge. The large main lounges have seating placed to allow for individual or group activities. The dining room in each unit is spacious. The communal areas are easily accessible for residents using mobility aids or staff assistance. |
| 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 of the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.  There is a secure area for the storage of cleaning and laundry chemicals for the laundry. The chemical provider monitors the use of chemicals and laundry processes.  There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The service provides a clothes labelling service for residents. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster policies and procedures to guide staff in managing emergencies and disasters. Induction includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The facility has an in-built generator in the event of a power failure that maintains essential services. There are civil defence supplies centrally located. Supplies of stored drinkable water is held in ceiling tanks. There is at least three days of food storage available. There are alternative cooking facilities available with three gas barbeques and gas cooking in the kitchen. The facility has an approved fire evacuation plan and fire drills take place six-monthly. The call bell system is evident in residents’ rooms, lounge areas and toilets/bathrooms. There are closed circuit cameras strategically placed throughout the facility. Staff advise that they conduct security checks at night, in addition to an external contracted company. A village car and mobile phones are available for staff should they go off-site into the village. |
| 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 ventilated and heated with underfloor heating. All rooms 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. The infection prevention and control committee is combined with the health and safety committee, which meets bi-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is sent out annually from head office and directed via the quality programme. The programme is reviewed annually at head office. A six-month analysis is completed and reported to the governing body. Infection control objectives for 2017 reflect the outcomes of surveillance and quality data. The clinical manager is the infection control officer with a job description outlining the responsibilities for infection prevention and control at the facility.  Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers and infection control signage throughout the facility. |
| 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 infection control officer has completed infection control and prevention MOH on-line training and attended the annual Ryman infection control education by teleconference. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, local laboratory, infection control consultants 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 were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed and reviewed in January 2017 by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. All staff can access the electronic policies. |
| 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/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions and training is provided both at orientation and as part of the annual training schedule. Hand hygiene competencies are completed six-monthly. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. |
| 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 in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections, and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officers complete a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality 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 in the care facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint or using an enabler. Staff training has been provided around restraint minimisation as well as management of challenging behaviour. |

# 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 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Eight long-term resident files were reviewed to determine timeframes around the first interRAI assessment. Initial assessments, long-term care plans and the first interRAI assessment had been completed within the required timeframes in four long-term resident files reviewed. | Four long-term resident files reviewed (three rest home and one dementia) did not have an interRAI assessment completed within 21 days of admission. | Ensure all new admissions have an interRAI assessment completed within 21 days of admission.  90 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.