

Bert Sutcliffe Retirement Village Limited - Bert Sutcliffe Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bert Sutcliffe Retirement Village Limited
Premises audited:	Bert Sutcliffe 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: 24 August 2017 End date: 25 August 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:	87



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ryman Bert Sutcliffe provides rest home, hospital (geriatric and medical) and dementia level of care for up to 150 residents. There were 87 residents at the time of the audit.

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, interviews with residents, family, management, staff and a general practitioner.

The village manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The village opened 31 October 2016 and the management team and staff have implemented the Ryman quality and risk management system.

Consumer rights

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

There is an established system implemented for the management of 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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant to the manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

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

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

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed confirmed they are involved in the care plan and review processes. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

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

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

The menu is designed by a dietitian at an organisational level and provides a range of dietary options that ensures 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.
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The building has a current building code of compliance. Construction remains underway in the village. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility.

All bedrooms have an ensuite. There are adequate numbers of communal toilets. There is sufficient space to allow for the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are 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. A dedicated laundry manager and his team manage laundry services 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.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint or enablers during the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection 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	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one regional manager, one village manager, one clinical manager) and fifteen care staff (seven staff registered nurses (RNs), four caregivers, and four activities staff) interviewed understand 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need</p>	FA	<p>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), three rest home (including one resident in a serviced apartment) and three dementia care) were signed by the resident or their enduring power of attorney (EPOA). Written consents were sighted for specific procedures.</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the resident’s file where required. Caregivers and registered nurses (RN) interviewed confirmed verbal consent is obtained when delivering care. Discussions with family members stated that the service actively</p>

<p>to make informed choices and give informed consent.</p>		<p>involves them in decisions that affect their relative's lives.</p> <p>Eight resident files of long-term residents have signed admission agreements and the two respite care residents had signed a short-term agreement.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include 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. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Seven complaints reviewed for 2017 (year to date) have been managed in a timely manner and are documented as resolved. The regional manager reported that all complainants are contacted by head office to ensure that their complaint is resolved. If the complaint is not resolved, the regional</p>

		manager becomes involved.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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. Eight relatives (two rest home, three hospital and three dementia) and eleven residents (six rest home with one in a serviced apartment, five 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 managers reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed in writing of the scope of services and any liability for payment for items not included in the scope.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support the residents' privacy and confidentiality. 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 whilst assisting with care.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process with family involvement. Instructions are provided in the admission agreement regarding responsibilities of personal belongings. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement in assessment and care planning and visiting is encouraged. Links are established with Ngati Whatua Orakei and other community representative groups as requested by the resident/family. There were no residents who identified as Māori at the time of the audit.</p>

beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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 multi-disciplinary 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 cultural values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. 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 all twenty-one staff (fifteen care staff, one assistant to the manager, one cook, two laundry staff, one cleaner, and one maintenance staff) confirmed their awareness and understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Many core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data are collected against each service level, and reported through to Ryman Christchurch (head office) 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 Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The system of data analysis and trend reporting is designed to inform staff at facility level. Management at facility level are then able to</p>

		implement changes to practice, based on the evidence provided.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Fifteen incident/accident forms and corresponding residents' files were reviewed and all identified that next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. There was one hospital resident with English as their second language. Family were able to interpret. The resident and family were not available to be interviewed. Staff reported that they have learned some words in the resident's language. Translation sheets are also available in the resident's room.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Bert Sutcliffe is a Ryman healthcare retirement village located in Birkenhead, Auckland. This is a recently built retirement village that opened on 31 October 2016. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care for up to 150 residents. This includes 30 serviced apartments that are certified to provide rest home level care. Forty-one beds in the care centre are dual-purpose (rest home/hospital) beds, forty-one beds are hospital only and thirty-eight beds (across two units) are available in the secure unit for dementia level of care.</p> <p>The village is on a sloping site with a ground level (level one) car park. The entrance and reception is on level five of the care centre. The care centre is across four levels (level 2, 3, 4, & level 5 is the entrance/administration area) with serviced apartments across six levels (level 1,5,6,7,8, and 9). Level two includes two 19-bed dementia units. There were 16 of 19 residents in one unit and 11 of 19 residents in the other unit. On level three, there were 29 hospital residents in the 41-bed hospital unit including two hospital residents on respite. On level four, there were three hospital residents and 27 rest home residents in the 41-bed dual-purpose unit including two rest home residents on respite. There was one rest home resident in serviced apartments on level five.</p> <p>No residents have been admitted to the care centre for the Ryman complimentary 48-hour stay since the facility opened.</p>

		<p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2017 are defined with evidence of regular reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been in the role since August 2016. She has more than seven years of experience in aged care management and has attended over eight hours annually of professional development activities relating to managing a retirement village. The village manager is supported by a regional manager, an assistant to the manager and a clinical manager/RN.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager and assistant to the manager are responsible during the temporary absence of the village manager, with support provided from the regional manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Ryman facilities have a well-established quality and risk management system 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 managers and staff; and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly. Minutes are maintained. Annual resident and relative surveys for the care centre are scheduled to be completed later in the year. Quality improvement plans (QIP) are developed where opportunities for improvement are identified. Five QIPs have been established since the facility has opened and three of the five are signed off as completed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, as evidenced in staff meeting minutes. A revised policy (3 August 2017) confirmed that any residents who request the Ryman complimentary 48-hour stay are admitted to</p>

		<p>the care centre.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed showing trends in the data. Results are communicated to staff across a variety of meetings. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Health and safety policies are implemented and monitored. The village manager is the health and safety officer and is supported by health and safety representatives (maintenance staff, gardener, and clinical manager, assistant to the village manager). Health and safety meetings are conducted two-monthly. 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. Handrails have been installed in hazardous areas outdoors since their last audit. Ryman has achieved tertiary level ACC Workplace Safety Management Practice (expiry 31 March 2018).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of 15 incident/accident forms for 2017 identified that all are fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur. Neurological observations are completed if there is a suspected injury to the head.</p> <p>The village manager could identify situations that would be reported to statutory authorities. A section 31 folder is maintained that contains copies of section 31 reports.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Twelve staff files reviewed (one maintenance, one activities coordinator, seven caregivers, one laundry, one barista/receptionist, one gardener) included a signed contract, job description relevant to the role of the staff member, evidence of completed orientation programmes (general and specific to the position), application form and reference checks. Eight-week performance reviews are completed following employment and are scheduled annually thereafter.</p> <p>A register of RN and EN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme is scheduled to exceed eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Nursing staff (12 registered nurses (RNs) and 2 enrolled nurses) are supported to maintain their professional competency. Seven of fourteen RNs have completed their interRAI training. There are implemented competencies for nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>One of eighteen caregivers who work in the dementia unit has completed their dementia qualification and the remaining seventeen are enrolled and are working on completing their qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The clinical manager is an experienced registered nurse with a current practising certificate who works full time Monday – Friday.</p> <p>There are thirty serviced apartments certified to provide rest home level of care that are located across six floors. One rest home level resident was living in a serviced apartment on level five at the time of the audit. The serviced apartment SA) coordinator is an enrolled nurse and works Sunday – Thursday. The SA office is based on level five. The am shift is staffed by the unit coordinator or a senior caregiver with two (short shift) caregivers (7am – 1pm and 8am – 1pm). The pm shift is staffed with two (short shift) caregivers (4pm – 9pm and 4.30pm – 7pm). The remaining times are covered by the caregivers caring for rest home level residents. Staff communicate via mobile telecommunications. One serviced apartment resident who was interviewed reported that staffing levels are adequate.</p> <p>Twenty-seven rest home and three hospital residents were living in the rest home/hospital unit (4th floor). Staffing included a unit coordinator/RN or a staff RN, seven days a week on the am shift only. Two long shift and two short shift caregivers cover the am and pm shifts and two caregivers cover the night shift. The RN is based in the hospital</p>

		<p>(3rd floor) during the pm and night shifts. The clinical manager reported that the three hospital level residents living on the 4th floor ambulate independently and have been assessed as safe to reside on this floor.</p> <p>Twenty-nine hospital level residents were living on the 3rd floor. A unit coordinator/RN is rostered five days a week. Two staff RNs are rostered for the am shift and pm shifts and one RN is rostered for the night shift. The hospital floor is supported by adequate numbers of caregivers.</p> <p>There are two secure dementia units with a shared office between. There was a total of 27 residents (11 residents in one unit and 16 residents in the other unit). A unit coordinator (RN) oversees both units five days a week and an EN or senior caregiver is rostered in the role the other two days of the week. The RN in the hospital provides oversight for the pm and night shifts. Four caregivers (two long and two short shift) are rostered in the am, three long and one short shift are rostered in the pm and three caregivers are rostered for the night shift.</p> <p>Extra staff can be either be called in for increased residents' requirements or be requested to stay for a longer shift.</p> <p>Activities staff are scheduled seven days a week in the hospital and dementia units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded 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. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>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.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term and short-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>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, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. All staff interviewed could describe their role regarding medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all the units. Medication fridges were monitored weekly and all temperatures were within the acceptable range. There were no expired medications. All eye drops and creams were dated on opening. There was one rest home resident who had been assessed by the RN and GP as competent to self-administer.</p> <p>Twenty medication charts (six rest home, eight hospital, six dementia care) were reviewed on the electronic medication system. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications is entered into the electronic medication system. Medication charts had been reviewed at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	<p>FA</p>	<p>All food and baking is prepared and cooked on-site. The head chef is supported by a second chef, cooks, cook assistant (baking and sandwich preparation) and kitchen hands. All staff had been trained in food safety and</p>

<p>And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>chemical safety. The service has implemented an organisational initiative "Project Delicious" that has been designed to provide a choice of meals and meet all resident nutritional requirements. Food is plated by the chef and delivered via hot boxes to the units where they are served by care staff in each of the unit kitchen/dining rooms.</p> <p>The chef is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident dislikes and dietary preferences are documented on the weekly menu planner. Modified diets such as pureed/soft foods are provided.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored daily 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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents and should this occur 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.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. Ten files sampled indicated that all appropriate personal needs information was gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and reviewed, when there was a change to a resident's health condition. Care plans sampled were developed based on these assessments. The interRAI assessment tool is implemented and links to care planning.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed demonstrated service integration and input from allied health. Residents' care plans were resident-centred. Support needs and interventions were documented to reflect the resident goals and the residents' current health status. Family members interviewed confirmed 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 were included in the long-term care plan in all three dementia care resident files reviewed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. When a resident's condition alters, the registered nurse initiates a review and if required refers to a GP or nurse specialist consultant. Resident files evidence family are kept informed of any changes. Short-term care plans are developed and either signed off once resolved or transferred to the long-term care plan.</p> <p>Wound assessments, treatment and evaluations were in place for residents with current wounds. There were 17 wounds documented on the day of audit; nine in the hospital (four pressure injuries, one skin lesion and four skin tears) and eight wounds documented for rest home level (five skin tears, two skin lesions and one blister). There were no wounds documented for the dementia unit. The Ryman wound care nurse is involved in the management of complex wounds and pressure injuries. There is access to wound nurse specialist at the district health board (DHB). Adequate dressing supplies were sighted in the treatment rooms.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>FA</p>	<p>A diversional therapist (DT) coordinates and implements the engage programme in the dementia care area and an activity coordinator (AC) in each of the units (rest home, hospital and serviced apartments). Each unit has a separate programme with some integrated activities open to other groups of residents as appropriate. One AC is progressing through the diversional therapy qualifications, another AC has a Bachelor of Communication and one other has completed a Diploma in Health Services Management. Three activity coordinators have a current first aid certificate. The programme is delivered across seven days a week. 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. All activities staff had been trained to deliver the Ryman Triple A exercise programme. Rest home residents in the</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>serviced apartments attend either the serviced apartment programme or rest home programme. There are adequate resources available. One-on-one time is spent with residents who are unable to participate or choose not to be involved in the activity programme. Special events and theme days are celebrated. On the day of audit there were vibrant and busy preparations involving the community, staff and residents for a 'masquerade ball'. The movie theatre was showing 'Romeo and Juliet'. Village friends visit and participate in some activities. There is a visiting pianist. Pet assist animals visit regularly. Community links include visits by people in the community and regular outings to places of interest. All residents have the opportunity to go on outings in the mobility van or bus. Residents interviewed stated they were very happy with their decision to live here, staff were very kind and attentive and they felt it was 'really like a hotel, with the décor, the food and lots of activities on offer and you didn't notice it was a hospital too'.</p> <p>The dementia care unit has a 'sensory room' (including lava lamps, music, CDs, aromatherapy, pampering, massage and hand massage) and a 'quiet room' (a tranquil setting with butterfly themed décor, suitably arranged furniture and access to the outside garden). RNs interviewed state these two rooms have a profoundly positive influence on behaviour, families are involved and often will provide a hand massage for their loved one.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The rest home residents long-term care plans had been evaluated by registered nurses' six monthly. Hospital and dementia care residents had not been at the service six months (opened in March). Written evaluations describe the resident's progress against the residents identified goals. Changes to care are updated on the long-term care plan. There is at least a three-monthly review by the medical practitioner. Multi-disciplinary team (MDT) reviews are planned and involve families. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the residents' files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. There was evidence sighted of a resident's condition that had changed and the resident was referred for reassessment for another level of care (dementia to hospital level care). Discussions with the clinical manager and RNs identified that the service has access to a wide range of support through the GP, Ryman specialists, nurse specialists, hospice and contracted allied health services.</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building code of compliance (expiry 7 Sept 2017). Construction remains underway for the village. This area is fenced off and safe. The facility employs a full-time head maintenance person. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule. Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration has been completed. Hot water temperatures in resident areas are monitored three-monthly. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>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.</p> <p>The dementia unit on level two is secure, it has an outdoor garden and lawn area, seating and shade and a separate smaller outdoor area off the sensory and quiet room area.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Fittings and fixtures are made of easy clean surfaces that meet infection control practice. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were assisting with personal care.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age</p>	FA	<p>The dementia care unit, rest home and hospital units have large open plan lounge areas. The lounges have seating placed to allow for individual or group activities. There is a large central kitchen and dining area in each unit as part of the open plan lounge, kitchen, dining experience. The communal areas are easily accessible for residents using mobility aids or staff assistance.</p>

appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits are completed as per the Ryman programme. There are dedicated cleaning and laundry managers with supporting cleaners and laundry staff on duty each day. All personal clothing and linen is laundered on-site. The laundry had an entry and exit door with separated clean and dirty rooms.</p> <p>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. The cleaning trolleys are kept in locked areas when not in use.</p> <p>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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The village has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities are in place. There are civil defence kits in the facility and adequate water storage on-site.</p> <p>The call bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms. The call bell system is linked to staff pagers and to the call bell panels. Residents can choose to wear an alarm pendant which is alarmed if they remove and walk away from it. Staff also use a telecommunications system to answer the phone at reception after hours and to communicate with each other if assistance is needed.</p> <p>Security systems are being implemented to ensure residents are safe. Staff confirmed that they conduct security checks at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight.</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. 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. There are monthly benchmarking and management meetings. The clinical manager is the infection control officer with a job description outlining the responsibilities for infection prevention and control at the facility.</p> <p>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.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>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 nurse has completed infection control and prevention training through online training and previously with bug control. 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.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There is a comprehensive suite of infection prevention and control policies appropriate for the size and complexity of the service. Existing policies reflect the infection prevention and control standard SNZ HB 8134:2008, legislation and good practice. The infection prevention and control policies link to other documentation and cross reference where appropriate. Policies are readily accessible to staff.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection prevention and control nurse 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. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs as needed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	<p>FA</p>	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Systems in place are appropriate to the complexity of service provided. All infections are reported on an electronic register and the infection prevention and control nurse receives a monthly report from Team Ryman. 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</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>programme. The infection prevention and control nurse uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. The service has reduced urinary tract infections. There have been no outbreaks in the care facility.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. The clinical manager is the restraint coordinator. On the day of audit, there were no residents with restraint or enablers. Residents who are falling frequently have been assessed as unsafe to be restrained.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.