

Edmund Hillary Retirement Village Limited - Edmund Hillary 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: Edmund Hillary Retirement Village Limited

Premises audited: Edmund Hillary 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: 27 September 2018 End date: 28 September 2018

Proposed changes to current services (if any): One room in the dual-purpose wing has been assessed as suitable for use as a double (shared) room for either rest home or hospital level of care. This room was initially built as a day care area, so is more than

twice the size of a standard care room. It was then converted into a single bedroom, the reconfiguration would allow couples to share the space. This increases bed numbers from 235 to 236.

Total beds occupied across all premises included in the audit on the first day of the audit: 187

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

Edmund Hillary is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 236 residents. There were 187 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, and interviews with residents, family, management, staff and a general practitioner.

One room in the dual-purpose wing has been verified at this audit as suitable for use as a double (shared) room for either rest home or hospital level of care. This room was a day care room, the reconfiguration would allow couples to share the space.

The village manager is appropriately qualified and experienced and is supported by an assistant manager and a clinical manager/registered nurse. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

Areas of continuous improvements were identified around reducing falls in the rest home and hospital, food services, laundry services and the restraint minimisation programme.

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 Māori Health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and (where appropriate) their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets timeframes established by HDC.

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 manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

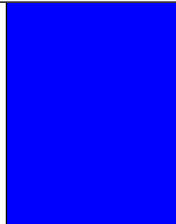
A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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. On-going education and training for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. 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.		All standards applicable to this service fully attained with some standards exceeded.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		All standards applicable to this service fully attained with some standards exceeded.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have en-suites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There are spacious lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities. Resident rooms are spacious and allow for safe movement of staff and mobility equipment. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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.		All standards applicable to this service fully attained with some standards exceeded.
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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. The service had four residents assessed as requiring the use of restraint and no residents required an enabler. Staff regularly receive 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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

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	3	47	0	0	0	0	0
Criteria	4	97	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 Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as part of the annual in-service calendar. Interviews with thirty-three staff (eleven caregivers on the am and pm shifts (four rest home, four hospital, two dementia, one serviced apartment), eleven nursing staff (four-unit coordinators/registered nurses (RNs), six staff RNs, one enrolled nurse), one chef, one maintenance, two laundries, one household staff, one dietitian, and five activities officers) confirmed their understanding of the Code. Staff could provide examples of how the Code applies to their job role and responsibilities. Fourteen residents interviewed (four rest home and ten hospital level) and seven relatives (one rest home, two hospital and four dementia unit) confirmed that staff respect privacy and support residents in making choices where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all fourteen resident files reviewed (four rest home- including one serviced apartment resident and one respite resident, seven hospital including one ACC resident and three dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. All residents in the dementia unit have activated EPOA's.</p>

provided with the information they need to make informed choices and give informed consent.		
<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>	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.
<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>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes includes opportunities to attend events outside of the facility including activities of daily living, for example, shopping. There is an onsite café and a shop as well. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain actively involved in community and external groups. Relatives and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). Six complaints have been lodged in 2018 (year to date). There is evidence of complaints received being discussed in staff and management meetings. All complaints received were investigated and were documented as resolved. The village manager reported that he makes every effort to meet face to face with complainants.</p>

		Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed. The village manager or the assistant manager discuss the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment of 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	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involved residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p> <p>Interviews with caregivers described how choice is incorporated into resident care provision.</p> <p>One room in the dual-purpose wing has been assessed as suitable for use as a double (shared) room for either rest home or hospital level of care. A privacy curtain is in place.</p>
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	FA	Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. A letter of invitation is sent to local Iwi annually. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. A kapa haka group attended and performed at a portrait unveiling of Edmund Hillary and have been invited and returned on several occasions. Cultural needs are addressed in the resident's care plan. At the time of the audit, no residents identified as Māori.

acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their cultural values and beliefs.</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. Staff sign a code of conduct/house rules, professional boundaries policies and procedures and a policy around bullying during their induction to the facility. The monthly full facility meetings include discussions on professional boundaries and concerns as they arise. Interviews with three managers (village manager, clinical manger, assistant manager) and staff confirmed their awareness 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. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data is collected against each service level. It is 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. Quality improvement plans (QIPs) are developed where results do not meet targets.</p>

		<p>MyRyman electronic resident information (eg, care plans, monitoring charts) have been implemented that allow for more one-on-one time with residents and less paper-based documentation. Interventions (eg, weight management, falls management strategies, pain management, behaviour management) documented on myRyman are implemented and are reviewed daily by a registered nurse. MyRyman care plans provide evidence to indicate when cares are being delivered. Interviews with care staff confirmed that although there has been a settling in time for implementation of myRyman, the system allows for a greater amount of time to be spent reviewing the care plan with the resident in the resident's room and assists caregivers in remembering to record when specific cares are being delivered (eg, turning charts, food and fluid intake and output). Another positive aspect of the myRyman system is notification to the care staff when there is a change to the resident's care plan.</p> <p>A general practitioner (Third Age medical practice) visit the facility daily, Monday – Friday with 24/7 on-call services in place. GP visits can often be as frequent as one GP seeing residents in the morning and another GP seeing patients in the afternoon. Links are embedded with allied health professionals. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists. The health and safety programme has introduced a 'stop and think' employee campaign. Staff complete cards to identify risk ratings and hazard controls. The service has strengthened communication via six-monthly multidisciplinary meetings and a monthly newsletter.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to</p>	<p>FA</p>	<p>Edmund Hillary is a Ryman healthcare retirement village. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. It provides rest home, hospital and dementia levels care for up to 235 residents. This includes 40 serviced apartments certified to be able to provide rest home level care. The units are broken down into the following. (i) Aoraki unit is a 43-bed dual-purpose unit; (ii) Ollivier unit is a 42-bed hospital unit; (iii) Kathmandu unit is a 30-bed hospital unit; (iv) Himalaya unit is a 50-bed rest home unit; (vi) Tibet special care unit is a 30-bed dementia unit.</p> <p>As part of this audit, one room in the dual-purpose wing has been verified as suitable for use as a double (shared)</p>

<p>the needs of consumers.</p>		<p>room for either rest home or hospital level of care. This room was a day care room, the reconfiguration would allow couples to share the space. This increases bed numbers from 235 to 236.</p> <p>Occupancy during the audit was 187 (63 rest home level residents (including seven in the serviced departments), 94 hospital level residents and 30 dementia level residents. There were three rest home level residents on respite and one hospital level resident on ACC.</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values and beliefs are documented that are specific to Ryman Edmund Hillary. Organisational objectives for 2018 are defined with evidence of monthly reviews and quarterly reporting to Ryman Christchurch on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2018 objectives.</p> <p>The village manager at Edmund Hillary has been in the role for over five years. An assistant manager and a clinical manager (registered nurse) both provide management support to the village manager. The clinical manager has been in the role for over four years and the assistant manager has been in the role since 2007. The management team is supported by a regional manager who was also present during the audit as a support person.</p> <p>The management team have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The assistant manager and clinical manager are responsible during the temporary absence of the village manager. The unit coordinators/RNs are responsible for clinical operations during the temporary absence of the clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>Edmund Hillary has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers and staff and review of management and staff meeting</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>minutes, demonstrates their involvement in quality and risk management activities.</p> <p>Resident meetings are held two monthly for each wing and relative meetings are held six monthly. The village manager attends the meetings and minutes are maintained. Resident and relative surveys are completed annually. Results for the February 2018 survey reflected improvements compared to 2017 in all areas but one (building/grounds). A quality improvement plan was implemented to address the grounds.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in staff meeting minutes.</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, meeting sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings. A health and safety officer (assistant manager) is appointed who has completed stage one health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice to March 2019. A review of the hazard register and the maintenance register indicates that there is resolution of issues identified. All contractors are inducted to health and safety processes by maintenance staff. All new staff are inducted and orientated to the facility and are advised of the health and safety programme. There is also annual in-service training.</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Falls have showed a reduction for hospital level residents over the past six months in the hospital and have remained low (below the threshold) for the 2018 calendar year for the rest home level residents and has resulted in a rating of continuous improvement.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident reports are completed</p>

<p>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>electronically on V-care for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident reports (eg, witnessed and unwitnessed falls, skin tears, challenging behaviours) identified that all are fully completed and include follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations would be reported to statutory authorities. Examples were provided which included notification to public health authorities for two infectious outbreaks (April 2017 and June 2018), one coroner's inquest (open and awaiting a response), one police investigation for a missing resident (Feb 2018) and one DHB complaint (closed).</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 (HR) policies including recruitment, selection, orientation and staff training and development. Each staff HR file out of fifteen staff files reviewed (six caregivers, six registered nurses, two activities coordinators/diversional therapists, one housekeeper) included a signed contract, job description relevant to the role the staff member is in, police check, induction, application form and two reference checks. The assistant manager confirmed that staff are not allowed to begin employment until reference checks are completed. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of registered nurse and enrolled nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. A general orientation programme that is attended by all staff covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. Training is offered multiple times/days to ensure that staff are able to attend. Staff also complete three competency questionnaires annually. Registered nurses are supported to maintain their professional competency. Fourteen of twenty-six registered nurses have completed their interRAI training and two RNs were in training at the time of the audit. RN's</p>

		<p>and EN's attend journal club. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including (but not limited to) medication competencies and insulin competencies.</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 village manager, assistant manager and clinical services manager/RN work Monday – Friday.</p> <p>Aoraki wing (occupancy 31 hospital and 10 rest home level residents) is staffed with a unit coordinator/RN Tuesday – Saturday. Two staff RNs cover both the AM and PM shifts and one RN covers the night shift. The am shift is staffed with three long and four short shift caregivers, the PM shift is staffed with three long and three short shift caregivers and the night shift is staffed with two long shift caregivers. This wing is where the dual-purpose beds are being utilised. It is also where the double room for rest home and/or hospital level of care was assessed for certification as a double room.</p> <p>Ollivier wing (occupancy 34 hospital level residents) is staffed with a unit coordinator/RN Tuesday – Saturday. Two RNs cover the AM shift, and two RNs cover the PM shift. One RN covers the night shift. The AM shift is staffed with four long and four short shift caregivers, the PM is staffed with two long and four short shift caregivers and the night shift is staffed with two long shift caregivers. In addition, a fluid assistant is rostered on the AM shift and a lounge carer is rostered on the PM shift.</p> <p>Kathmandu wing (occupancy 29 hospital level residents) is s staffed with a unit coordinator/RN Sunday – Thursdays. One RN covers the AM shift with a second RN staffed the two days the unit coordinator is not available. One RN is staffed on the PM shift and one RN is staffed on the night shift. The AM shift is staffed with two long and three short shift caregivers, the PM shift is staffed with two long and short shift caregivers and the night shift is staffed with two long shift caregivers. In addition, a fluid assistant is rostered on the AM shift and a lounge carer is rostered on the PM shift.</p> <p>Tibet wing (occupancy 30 dementia level residents) is a secure unit with one-unit coordinator/RN Tuesday – Saturday. One staff RN covers the AM shift with a second RN rostered on the two days that a unit coordinator is not available. One RN covers the PM shift from 1500 – 2100). The AM shift is staffed with two long and one short shift caregivers, the PM shift is staffed with two long shift caregivers and the night shift is staffed with three long shift caregivers. In addition, a dining assistant is rostered from 1000 – 1400 and a lounge carer and servery assistant are rostered on the PM shift.</p> <p>Himalaya wing (46 rest home level residents) is staffed with one-unit coordinator/RN Sunday – Thursday. One staff RN covers the AM shift with a second RN rostered on the two days that a unit coordinator is not available. The AM shift is staffed with two short and two long shift caregivers, the PM shift is staffed with two short shift and two long</p>

		<p>shift caregivers and the night shift is staffed with two long shift caregivers.</p> <p>Service apartments (7 rest home level residents) is typically staffed with one-unit coordinator/RN five days a week but due to one RN on leave, an enrolled nurse is acting in this role. An RN is rostered on the two days that the unit coordinator is not available. The AM is staffed with one long and one short shift caregiver, and the PM is staffed with two short shift caregivers (1600 – 2100). After 2100, the caregivers in the rest home wing (Himalaya) staff the serviced apartments. The call system is linked to their pagers.</p> <p>A 'coverpool' of staff (one RN four days a week, three caregivers four days a week, two caregivers two days a week and one housekeeper four days a week) are additional staff that are added to the roster to cover staff absences.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files (both hard copy and electronic) are protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation. Residents' files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry including information on the 48-hour complimentary service for village residents, short-term stays, rest home, hospital and dementia level of care services. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements (including the resident under ACC) and the one short-stay admission agreement for a respite care resident were signed and dated.</p>

services has been identified.		
<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>	FA	<p>Policy 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. Communication with family occurs.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurse and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (three hospital units, rest home, serviced apartments and dementia care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication fridges are checked weekly and temperatures sighted were within the acceptable range. There were three rest home residents and one hospital level resident self-medicating on the day of audit. Medications were stored safely in the resident's room. Three monthly self-medication competencies had been completed by the RN and authorized by the GP.</p> <p>There were no standing orders. There were no vaccines stored on site.</p> <p>Twenty-eight medication charts on the electronic medication system were reviewed (14 hospital, eight rest home and six dementia care). Medications are reviewed at least three monthly by the GP. The GP and the community mental health nurse review medications for dementia care residents. There was photo identification and allergy status recorded. As required medications had indications for use prescribed. The effectiveness of as required medications is recorded in the progress notes and on the electronic medication system. Medication administration observed complied with policy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	CI	<p>There is one head chef, two under cooks and five kitchen hands who cover the week between them. All have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. The food control plan has been submitted with a site visit scheduled for October 2018. There is a well-</p>

<p>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>equipped kitchen and all meals are cooked onsite. Meals are taken to the dining rooms in hot boxes, then transferred into bain maries and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder and on a whiteboard. There are snacks available at all times in the dementia unit. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were very satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys. Management liaise regularly with the head chef to monitor feedback and identify any areas for improvement. In the last six months the facility has introduced 'project delicious' to offer variety and choice and to cater for all dietary needs with positive feedback from residents and relatives</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>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the V-care system within 24-48 hours of admission for all residents entering the service including short-stay residents and residents admitted under the 48-hour complimentary service (as viewed in a previous file). InterRAI assessments had been completed for all long- term residents whose files were reviewed. Applicable V-care assessments are completed and reviewed at least six monthly or when there is a change to residents' health/risk. The outcome of all</p>

gathered and recorded in a timely manner.		assessments is reflected in the myRyman care plan. Behaviour assessments had been completed for the files of three dementia care residents with the outcomes included in the care plan.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs, resident goals and provide detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. MyRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, district nurse, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.</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>	FA	<p>When a resident's condition changes the registered nurse initiates a GP or nurse specialist consultation. Registered nurse interviewed state that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given).</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. Three chronic ulcers have had input from the GP. There are currently six pressure injuries including three grade 2's and two grade one facility acquired, and one non-facility acquired grade 3. The district nurse has had input into the pressure injury management as the wound was big managed in the community prior to admission. The clinical manager is the wound nurse champion for the facility and reviews wounds regularly. There has been input from the GP and wound care nurse specialist as required. Photos of wounds demonstrate healing progress. Pressure injury prevention equipment is available and</p>

		<p>is being used. Caregivers document changes of position electronically.</p> <p>Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A team of activity officers (all qualified diversional therapists – DT), activity assistants and lounge carers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The activity officers (DTs) work Monday to Friday in each of the five wings (refer 1.2.8) and are supported by a weekend activity team. The rest home programme is Monday to Friday and the hospital and dementia units are seven days a week.</p> <p>There is a weekly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home residents in serviced apartment can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. Village friends visit regularly and volunteer time with residents including chats, reading and pamper sessions. The service hires a mobility van for hospital outings. The service has a van for the rest home, dementia care and mobile hospital resident outings. Residents attend functions in the community such as the ‘opportunity’ monthly concerts and school productions. There are regular combined activities and celebrations held in the large lounges and atrium for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision.</p> <p>Activities in the dementia care units include triple A exercises, garden walks in the two courtyards and around the village, singing, happy hours, hand therapy, word games, knitting group and dancing. The men attend the combined units’ men’s group for activities and outings. The activity officer is on duty from 9.30 to 6pm and a lounge carer is on duty from 4 to 7pm. Resources are plentiful. Volunteers include the ukulele group, Pilipino cultural group and pet therapy visits (to all units).</p> <p>There are interdenominational church services held in the chapel with room visits as required. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father’s Day, Anzac Day and Christmas and theme days are celebrated. Junior school children and Kapa Haka groups visit.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed</p>

		identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The nine long-term resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Four residents (two hospital, one rest home and one dementia care resident) have not been at the service long enough for an evaluation. The respite care resident does not require an evaluation of care. The RN completes a daily evaluation for respite residents. The multidisciplinary review involves the RN, GP, caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one-three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.
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 residents had been referred to the wound care nurse specialist, geriatrician, mental health services for older people, dermatology and dietitian. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.

<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>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 holds a current warrant of fitness which expires 13 August 2019. There is a full-time facilities manager who supervises three maintenance men, one gas reader and five gardening staff. Contractors are available when required.</p> <p>Electrical equipment has been tested and tagged. The hoists and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained as are the indoor atrium and courtyards. There is an upstairs outdoor balcony area as well. All outdoor areas have seating and shade. The dementia unit garden is safely fenced. There is safe access to all communal areas.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</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</p>	<p>FA</p>	<p>All rooms within the facility have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are mobility toilets near all communal lounges. There are privacy signs on all toilet doors.</p>

requirements or receiving assistance with personal hygiene requirements.		
<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>There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the days of audit.</p> <p>In the dual-purpose unit there is one double room occupied by a married couple (rest home). The room has a lounge, bedroom and ensuite. There are call bells by each bed and in the ensuite. When in the lounge the residents wear a call bell pendant. There is ample space to provide care and privacy can be assured. This room has been verified as fit for purpose.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are dining rooms in each area. The dementia unit has two dining rooms and lounge areas. There is a shop, café, and hairdressing salon.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	CI	<p>All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaner’s’ trolley sighted were labelled. There is a sluice room on each floor for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept locked when not in use.</p> <p>In 2017 the facility commenced a laundry project. They installed a labelling machine and the ‘purple bag system in</p>

<p>appropriate to the setting in which the service is being provided.</p>		<p>order to reduce the amount of unnamed/missing clothes items. This has project has been evaluated and is successful.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The care centre has an approved fire evacuation plan and fire drills six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has emergency generators on site that are serviced by an external contractor. It also has two gas BBQs available in the event of a power failure and torches. Emergency lighting is in place, which will last for four hours. There are civil defence kits in each unit and adequate stores of drinkable and non-drinkable water on site.</p> <p>The “Austco Monitoring programme” call bell system is available in each resident room. There are call bells and emergency bells in communal areas. There is a nurse presence bell when a nurse/carer is in the resident room; a green light shows staff outside that a colleague is in a particular room. The call bell system has a cascading system of call recognition that cascades if not responded to within a certain time from the primary nurse (caregiver) to the unit coordinator, to the clinical manager and to the village manager. The system software is monitored. In the dementia unit, the system includes an electronic beam management technology which is used to alert staff on the movements of residents in their rooms who are at high risk of falling. Alerts are sent electronically to staff for those high-risk residents who are attempting to get out of bed unsupervised. Once the resident gets out of bed at night the ensuite light automatically comes on. Rest home residents in serviced apartments have call bell pendants. The facility has its own security staff who are employed from 5.30 pm to 6 am seven days a week. The service utilises external security cameras and has internal cameras in the corridors in the dementia/special care unit to promote resident safety.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. The entire site is smoke free.</p>

comfortable temperature.		
<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>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is a registered nurse based in the hospital. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets two monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitizers are placed appropriately within 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>	FA	<p>The infection prevention and control committee (combined with the health and safety committee) meet two monthly. The infection control officer has been in the role since December 2017 and completed an induction to the role and attended an external infection control half day May 2018. The infection control officer is allocated four hours per month to collate infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections. The infection and prevention officer have access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory 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</p>	FA	<p>There are comprehensive infection prevention and control policies that are 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 referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.</p>

<p>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>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 control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the v-care system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There have been two outbreaks since the last audit. In April 2017 there was an unconfirmed gastroenteritis outbreak. The second outbreak in June 2018 was a confirmed norovirus outbreak. Email notifications for both</p>

		outbreaks were sighted.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	CI	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The organisation continues to work towards becoming restraint-free.</p> <p>During the audit, there were no residents using enablers and only four residents using restraints. This is a high achievement considering that there were 187 residents in the care facility, and has resulted in a rating of continuous improvement.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. There have been improvements made in reducing the number of restraints used without experiencing an increase in the number of residents' falls.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital-level residents' files were</p>

of consumers is undertaken, where indicated, in relation to use of restraint.		reviewed of residents using a restraint (one bed rails, one chair brief). Completed assessments considered those listed in in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a unit coordinator/registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents' care plans. Internal audits, conducted six-monthly, measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two residents' files where restraint was in use.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly as part of the ongoing reassessment for the residents on the restraint register, and six-monthly as part of the care plan review. Families are included as part of this review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator, clinical manager, GP and unit coordinator where the applicable resident(s) are located. Meeting minutes include (but are not limited to) a review of any residents using restraints or enablers, any updates to the restraint programme, and staff education and training and review.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Falls have reduced for hospital level residents over the past six months and have remained low (below the threshold) for the 2018 year for rest home level residents.</p>	<p>Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits. Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: highlighting residents at risk through a colour coding (traffic light) system; providing falls prevention training for staff; ensuring adequate supervision of residents; and encouraging resident participation in the activities programme; physiotherapy assessments for all residents; routine checks of all residents specific to each resident’s needs (intentional rounding); the use of sensor mats and night lights; and increased staff awareness of residents who are at risk of falling.</p> <p>Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly and is regularly discussed at staff meetings. A review of the data evidenced that the falls rate is below the Ryman benchmarked target (11/1000 bed nights) for both rest home and hospital level residents. For rest home level residents, the average rate was 8.1/1000 bed nights (April 17 – Aug 18) and for hospital level residents the average number of falls is 8.9/1000 bed nights (Apr 17 – Aug 18). Any spikes in data were explained with actions taken.</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>Ryman has introduced a number of systems to ensure residents nutritional needs are met and the dining experience improved. This has been achieved with the introduction of project delicious in February 2018.</p>	<p>The four-week rotating seasonal menu offers a variety of choices including three main dishes for the midday and two choices for evening meal including a vegetarian option. Gluten free meals are offered on the menu. Dietary needs are met through the project delicious menu options. The service has liaised with food suppliers to improve quality of suppliers including access to specialised pure foods for pureed options. Other initiatives include an easy to read laminated menu card for ease of weekly ordering. There is a glossary on the back of each weekly menu card explaining the terminology of meals/desserts to assist the residents and staff when ordering meals. The dining rooms (viewed) have been set up to reflect an ambience of relaxed dining as observed during meal times.</p> <p>Evaluation of the project delicious menu and dining experience has been measured by; 1) feedback from residents at the two monthly resident meetings held (in each unit) around the project delicious meals. There have been very positive comments recorded in the minutes sighted since the introduction of project delicious, 2) ongoing education for staff around food services, dining room etiquette, nutrition and hydration, 3) feedback forms sighted evidenced residents and relatives are very satisfied with the meals and choices provided and 4) interviews with 14 residents and seven relatives all stated the meals (choice, quality and presentation) were very good to excellent. The service has been successful in providing excellence in food services.</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>CI</p>	<p>Laundry processes reflect an area of continuous improvement.</p>	<p>The laundry project initiated in 2017 aimed to reduce un-named clothes, return clothing to residents in a timely manner and reduce complaints around the laundry service. Each resident was provided with individually labelled laundry bags for their personal use. These labelled 'purple' bags were seen in residents' ensuites. The organisation purchased a labelling machine and the laundry personnel label all residents' personal items on admission and as required. Staff received training on the new machine and the laundry processes.</p> <p>The two laundry personnel interviewed on the days of audit could describe the procedure for reducing the amount of un-named/missing clothing. There was no un-named/missing clothing on the days of audit.</p> <p>Residents and relatives were informed of the laundry procedures. Laundry audits have evidenced an improvement in laundry procedures. The service has been successful in reducing the amount of un-named/missing clothing with zero complaints in 2018. The</p>

			recent satisfaction survey demonstrated an increase in resident/relative satisfaction from 76% in 2017 to 82.6% in 2018.
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	No enablers and only four restraints were in place for a facility that had an occupancy of 187 residents.	There were no residents who required an enabler and only four residents who required the use of a restraint (one bedrails and three chair briefs) during the audit which is to be commended when linked to the size of this facility with 187 residents (with 94 hospital level residents). The low number of restraints used has not been impacted by resident falls (link CI 1.2.3.6). Strategies implemented to minimise the use of restraint include mandatory staff education and training that includes staff competencies, encouraging residents at risk to not remain in their room, lounge carers, anticipating resident's needs (eg toileting) and intentional rounding of residents at risk. The restraint coordinator reported that a significant amount of time is spent educating families on the benefits of not using restraint.

End of the report.