

Possum Bourne Retirement Village Limited - Possum Bourne Retirement Village

Introduction

This report records the results of a Surveillance 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:	Possum Bourne Retirement Village Limited
Premises audited:	Possum Bourne Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 February 2019 End date: 19 February 2019
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:	118

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Possum Bourne is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia levels of care for up to 122 residents in the care centre and rest home level of care for up to 30 residents in serviced apartments. On the day of audit there were 118 residents. This included two rest home level residents in the serviced apartments.

The service is managed by an experienced village manager and clinical manager/registered nurse. The residents and relatives interviewed spoke positively about the care and support provided.

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

The service has addressed the one shortfall around completion of interRAI assessments.

No improvements were identified as a result of this surveillance audit.

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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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 if a resident is involved in an incident or has a change in their current health. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews.

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

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

Registered nursing cover is provided seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Electronic myRyman care plans demonstrate service integration, are individualised and evaluated six-monthly. Monitoring forms are utilised. The resident/family/whānau interviewed confirmed they are involved in the care plan process and review.

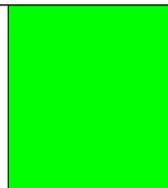
The diversional therapists and activity coordinators provide an activities programme in each unit. The recreational needs of the residents are met through a varied and interesting programme which includes the families and community. There are 24-hour activity plans for residents in the dementia care units that are individualised for their needs.

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

Meals are prepared on-site. The menu is designed by a dietitian at organisational level and provides menu options. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care units. Residents interviewed commented positively on 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.

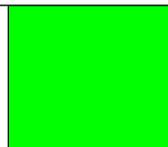


Standards applicable to this service fully attained.

The building has a certificate for public use. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraints and enablers. There were no residents with a restraint or an enabler at the time of the audit. Staff receive training around restraint minimisation.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control coordinator (clinical coordinator) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control.

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	16	0	0	0	0	0
Criteria	0	41	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented. The village manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. The facility has an up-to-date on-line complaint register. Concerns and complaints are discussed at relevant meetings. One written complaint was made in 2018 and no complaints have been received in 2019 (year-to-date). Acknowledgement of the 2018 lodged complaint, an investigation and communication with the complainant were included in the register. This complaint is documented as resolved.</p> <p>One complaint was received by the health and disability commissioner (HDC) in December 2017 relating to resident cares. This complaint was documented as being discussed at relevant meetings (eg, clinical meetings). A number of corrective actions have been implemented addressing clinical education (eg, vital signs (1 and 8 August 2018), recognising change (27 June and 25 July 2018), neuro assessments (journal club, July 2017), observations (journal club, July 2018), assessing the unwell resident (journal club, September 2018)). In addition, RNs and ENs have been issued with new quick reference pocket cards. No further actions are required as per HDC.</p> <p>Interviews with residents and relatives confirmed they were provided with information on the complaints process.</p>
Standard 1.1.9: Communication	FA	There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Fifteen incident forms selected for review evidenced that family are informed

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>of accident/incidents. Three relatives interviewed (two dementia, one rest home) stated that they are informed when their family member's health status changes and/or if there has been an adverse event.</p> <p>Residents' meetings occur two monthly and family meetings take place six-monthly. The service produces a monthly newsletter "Possums Post" that is readily available to all residents, relatives and visitors to the facility. The information pack and admission agreement include payment for items that are not subsidised.</p> <p>Seven residents interviewed (four hospital, three rest home) stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available. During the audit, one caregiver was observed speaking to a Chinese resident in their native language.</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>	<p>FA</p>	<p>Possum Bourne is a Ryman Healthcare retirement village providing rest home, hospital and dementia level care for up to 122 residents in the care centre. The facility is also certified to provide rest home level of care in 30 serviced apartments.</p> <p>The facility has four levels with care beds located on three of the four floors. The second level has two 20-bed secure dementia care units, the third level has 41 rest home beds (certified as dual-purpose which includes one double room for a couple if needed), and the fourth level 41 hospital beds (certified as dual-purpose which includes one double room for a couple if needed). Serviced apartments are spread across the four floors. On the day of audit, there were 118 residents (42 at rest home level of care with 2 of the residents in the serviced apartments, 39 residents at hospital level of care and 37 residents at dementia level of care (20 residents in one unit and 17 in the other unit). There was one hospital level resident on ACC, and one (private paying) rest home level resident on respite care. All remaining residents were under the aged residential care contract (ARCC).</p> <p>Three residents have been admitted under the 48-hour complimentary care package since the facility opened (two in 2018 and one in 2019 (year to date). One file was selected for review. A signed agreement was in place. The resident underwent a full assessment (eg, activities of daily living, risks identified (eg falls risk), medical history, pain management). The assessment was completed by an RN. Progress notes were documented for every eight-hour shift. A discharge summary was documented that was within the 48-hour time limit.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually and are regularly reviewed. Evidence in staff and management meeting minutes reflected discussions around the objectives.</p> <p>The village manager (non-clinical) at Possum Bourne was in the role at another Ryman facility for two years before commencing as village manager at Possum Bourne in July 2016. He is supported by an assistant to the manager (non-clinical), who carries out administrative functions and an experienced clinical manager (appointed August</p>

		<p>2016) who oversees all clinical care. The clinical manager is supported by four-unit coordinators, one for each level of care. The management team is also supported by a regional manager.</p> <p>The village manager and clinical manager have attended in excess of eight hours of professional development per year relating to managing an aged care facility.</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>	<p>FA</p>	<p>Possum Bourne has implemented a 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 management team (village manager and clinical manager) and 18 staff (one assistant to the manager, five caregivers across the AM and PM shifts, six registered nurses (RNs) (two staff RNs and three unit coordinators/RNS, one enrolled nurse (unit coordinator serviced apartments), one maintenance, three activities coordinators, one health and safety representative) and review of management and staff meeting minutes demonstrated the employees involvement in quality and risk activities. Meetings have been held as scheduled and evidence discussion around quality data including the outcomes of survey, internal audits, concerns/complaints, infection control and accident/incidents.</p> <p>Resident surveys were last completed in February 2018 and are currently underway for 2019. A relative survey was last completed in March 2018. Results were fed back to participants and staff. Quality improvements were raised for one area identified in the resident survey, addressing concerns related to laundry services.</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 in accordance with the monthly team. These are communicated to staff, as evidenced in meeting minutes and sighted on the staff noticeboards.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. There is an internal audit schedule that is monitored by head office. Quality improvements plans (QIPs) are raised for areas of non-compliance. QIPs implemented since the last audit were reviewed (eg, increase in falls rates (overall and specifically in the dementia unit, one complaint lodged with HDC relating to resident cares, laundry services). QIPs are signed off when completed. Outcomes are communicated to staff across a variety of meetings and reflect actions being implemented.</p> <p>Falls prevention strategies are in place with examples provided (eg, perimeter mattresses, falls assessments and exercises by the physiotherapist, floor sensor mats, bed sensor mats and motion sensor lights in the dementia unit, appropriate footwear and falls prevention education). An example was provided by the clinical manager that described a resident as a frequent faller, the resident's trends analysis and the corrective actions taken that reduced</p>

		<p>the number of falls by this resident.</p> <p>Health and safety policies are implemented and monitored as evidenced in the two-monthly combined health and safety and infection control meetings. The village manager has overall responsibility for the health and safety programme. A health and safety representative is appointed who was interviewed during the audit. Both the village manager and health and safety representative have completed stage-one health and safety training. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. Improvements are made where indicated. The hazard registers for generic and specific hazards are reviewed a minimum of annually. The internal audit programme is linked to health and safety (eg, food safety audits, emergency call bell audits, environmental audits, fire safety audits, waste management audits). Staff document hazards and near miss events in a designated book that is held at reception. All staff complete health and safety training during their induction to the facility. Maintenance staff are responsible to orientating external contractors. Back-up support is provided by reception staff. The auditor observed one contractor undergoing their health and safety induction during the audit.</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>	FA	<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(s) required. A review of fifteen incident/accident reports (eg, witnessed and unwitnessed falls, episodes of challenging behaviours) from across all areas of the service identified that all are fully completed and include follow-up by a RN. The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control).</p> <p>The village manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Section 31 reports have been completed since the previous audit pertaining to notification of pressure injuries. No other Section 31 reports have been required.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, one-unit coordinator/enrolled nurse, one-unit coordinator/registered nurse, three staff registered nurses, three caregivers) included a signed employment contract, job description relevant to the role the staff member is in, police check, induction paperwork, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff. A register of RN and enrolled nurse (EN) practising certificates are maintained</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses attend regular journal club meetings. The clinical manager reported that the RNs are currently working on their professional development recognition folders.</p> <p>Twenty-two caregivers work in the dementia unit. Six have completed their dementia qualification. Eight caregivers are progressing through their dementia unit standards and have been employed for less than eighteen months. Eight caregivers have been employed less than six months and have not signed a training agreement yet to complete their dementia qualification.</p> <p>Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. There are currently 18 RNs working at Possum Bourne. Nine RNs (including the clinical manager) have completed interRAI training.</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 to the manager and clinical services manager/RN work Monday – Friday.</p> <p>The hospital wing (occupancy 39 hospital residents, two rest home level residents) is staffed with a unit coordinator/RN Tuesday - Saturday. Two staff RNs cover the AM and the PM shifts, and one RN covers the night shift. The AM shift is staffed with four long shift and four short shift caregivers, the PM shift is staffed with two long shift and four short shift caregivers and the night shift is staffed with three long shift caregivers. Activities staff are rostered seven days a week from 9:30 am – 4:30 pm. One fluid assistant covers the AM shift (short shift) seven days a week and a physiotherapy assistant covers the AM shifts five days a week (short shift). A PM shift lounge carer is rostered from 4.00 pm – 8.00 pm seven days a week.</p> <p>The dementia unit is split into two units with 37 residents in total. Twenty residents were residing in one unit and seventeen were living in the other unit. A designated unit coordinator/RN works the AM shift (Sunday - Thursday). Two RNs are staffed on the AM shift (one for each unit) and one RN covers both units during the PM shifts. The AM shift is staffed with one long and one short shift caregiver on each unit. The PM shift is staffed with four caregivers (two long shift and two short shift) to cover both units. The night shift is staffed with three long shift caregivers. One caregiver is on each unit and the third caregiver floats between the two units. A lounge carer is rostered seven days a week from 9.00 am – 4.00 pm and 4.00 pm – 8.00 pm. Activities staff are rostered five days a week.</p> <p>The rest home wing (38 rest home level residents) is staffed with one-unit coordinator/RN Tuesday – Saturday. A</p>

		<p>second RN is rostered on the two days that the unit coordinator is not available. The AM and PM shifts are staffed with two short and two long shift caregivers and the night shift is staffed with two long shift caregivers.</p> <p>Service apartments (that includes two rest home level residents) is staffed with one-unit coordinator/EN five days a week. A senior caregiver is rostered on the two days that the unit coordinator is not available. In addition, the AM shift is staffed with two short shift caregivers. Activities staff are available Monday – Friday. The PM shift is staffed with two short shift caregivers to 9.00 pm. After 9.00 pm, a designated caregiver in the rest home wing covers the serviced apartments via a pager system. Rest home level residents are clearly marked on the resident register and are communicated to the senior rest home level caregiver during handover (confirmed during an interview with the applicable caregiver).</p> <p>A 'cover pool' of staff (RN cover 32 hours per week, caregiver cover 72 hours per week) are additional staff that are added to the roster to cover staff absences. In addition, an additional RN covers one day a week to complete interRAI assessments.</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.</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 MOH guidelines. Medication reconciliation of monthly blister packs is completed by two RNs and the pack signed and dated. Any errors are fed back to the pharmacy. Registered nurses, enrolled nurse and senior caregivers who administer medications have been assessed for competency. Education around safe medication administration has been provided. The service uses an electronic medication system. Caregivers, RNs and enrolled nurse interviewed could describe their role in regard to medicine administration. There were two residents self-medicating 'as required' inhalers. Both had self-medicating competencies that were reviewed three-monthly. Medications were stored safely in all four units (rest home, serviced apartments, hospital and dementia care). There is a bulk supply medication available for hospital residents. Medication fridges are monitored daily with evidence of corrective actions for temperatures outside of the acceptable range. All eye drops were dated on opening.</p> <p>Fourteen medication charts were reviewed on the electronic medication system. All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system and progress notes.</p>
<p>Standard 1.3.13:</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by one other chef, a</p>

<p>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>cook assistant and a team of kitchen assistants to prepare and deliver the project "delicious" menu to the units. Project "delicious" provides daily menu options. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Menu choices are decided by residents (or staff if the resident is not able), and offer a choice of dishes for the midday meal and evening meal including a vegetarian option. The head chef receives dietary profiles for each resident and is notified of any dietary changes. Resident dislikes are mostly accommodated through the menu options; however, alternatives are provided if required. Diabetic desserts, pureed meals, food allergies and gluten free diets are accommodated. Meals are delivered to the units in hot boxes. Serving temperatures are taken daily in each unit. Nutritious snacks are available 24 hours in the dementia care units.</p> <p>The food control plan has been verified and expires 9 May 2019. Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Cook and cool temperatures are conducted where required. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Staff have been trained in food safety and chemical safety.</p> <p>Residents can provide feedback on the meals through resident meetings, survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</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. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP or NP visit or nurse specialist consultant. All myRyman care plans for long-term residents and the initial assessment for the respite care resident reflected the required supports to meet the resident's current health status. Interventions had been implemented as outlined in the care plans. 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 and RN to complete. Monitoring charts such as reposition charts, food and fluid charts, neurological observations, weight charts, blood sugar levels and pain monitoring charts and behaviour charts are well utilised.</p> <p>Wound assessments, treatment and evaluations were in place for a sample of 12 residents with wounds. Wound assessments and management plans are completed on myRyman. Wound assessment includes location of wound, size and photos and considers wound pain as part of the assessment. There were no residents with pressure injuries on the day of audit. The wound champion (shared role by clinical manager and hospital unit coordinator) reviews all complex and non-healing wounds at least weekly. When wounds are due to be dressed a task is automated on the RN daily schedule. The GP reviews non-healing and chronic wounds regularly. There are adequate pressure injury prevention resources available.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist</p>

		continence advice is available as needed and this could be described by the RNs interviewed.
<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>	FA	<p>There is a team of activities staff (diversional therapists and activities coordinators) who coordinate and implement the Engage activities programme across the rest home - Monday to Friday, hospital unit – Monday to Sunday, and dementia units Monday to Sunday. Rest home residents in serviced apartments can choose which programme they would like to attend (serviced apartment or rest home). There are some integrated activities such as entertainment and celebrations that is open to all other residents to attend including dementia care residents (as appropriate and under supervision).</p> <p>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 including Triple A exercises, baking, sensory activities, musical moments, making memories, outings and drives. A facility van is available for outings for all residents. A mobility van is hired for hospital residents. The lounge areas have seating placed for large and smaller group activities. One-on-one activities occur as well as regular walks out in the gardens. Daily contact is made with residents who choose not to be involved in the activity programme. Community visitors include canine friends, pre-school children, school children, entertainers, and church groups. Each unit has an active men's group. Residents are encouraged to maintain community links and some rest home residents</p> <p>The DT in the dementia unit is supported by lounge carer and caregivers to implement small group and individual activities for the residents in each of the two units. The engage programme is flexible and focused on meaningful activities including baking, walks, gardening and household activities. There are group activities, entertainment and men's club. There are weekly van outings for residents to go out on scenic drives and outings. Each unit has an outdoor walking pathway and gardens that are freely accessed. In the two dementia level myRyman files reviewed, all the information around activities to engage or distract residents over the 24-hour period were documented throughout the care plans in various sections.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the electronic files reviewed for long-term residents had been evaluated at least six-monthly with the care plan review. The resident (as appropriate) /family/whānau are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident and relative meetings and satisfaction surveys. Activities staff attend on-site and organisational in-services relevant to their roles.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>Electronic resident files reviewed identified that long-term care plans had been evaluated by registered nurses at least six-monthly or earlier as required. A written multidisciplinary review record is maintained that evidences family/resident involvement in the care plan evaluation process. Evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the myRyman care plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review.</p>

evaluated in a comprehensive and timely manner.		The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has posted a certificate for public use that was issued in September 2018. Plans are in place for issuance of a building warrant of fitness in September 2019. The facility employs a full-time maintenance person who has been involved in the construction of the building. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule which has been signed as completed (sighted). Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration are completed annually. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy 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 for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention officer (clinical manager) completes a monthly report. Monthly data is reported through all facility meetings and information including graphs and corrective actions are available in the staff room. The infection prevention and control programme links with the quality programme. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint or using an enabler. Staff training has been provided around restraint minimisation as well as management of challenging behaviour.

Specific results for criterion where corrective actions are required

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

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

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

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.