

Jane Mander Retirement Village Limited - Jane Mander 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:	Jane Mander Retirement Village Limited
Premises audited:	Jane Mander 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: 23 April 2019 End date: 24 April 2019
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	113



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

Jane Mander is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia levels care for up to 142 residents. On the days of the audit there were 113 residents including three residents receiving rest home level of care in the serviced apartments. A village manager, who is supported by the clinical manager, manages the service. The residents and relatives interviewed spoke positively about the care and support provided.

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

There are five areas of continuous improvement awarded around good practice, reducing falls, health and safety, food services, and laundry services.

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.		All standards applicable to this service fully attained with some standards exceeded.
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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. 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. 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 and coordinated, and are appropriate to the needs of the residents. A village manager, assistant to the manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

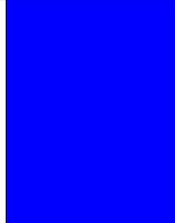
A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported 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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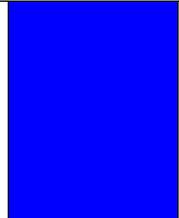
There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate 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. Safety data charts are available. The building holds a current warrant of fitness. All rooms are single and have ensuites. Communal areas are easily accessed. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is a first aider on duty at all times.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had ten residents assessed as requiring the use of restraint and two residents who requested 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 (clinical manager) 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. There have been no outbreaks.

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	5	96	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 twenty-five staff (one assistant to the manager; eight caregivers across the am and pm shifts who work in the rest home, dementia, hospital and serviced apartments (two rest home, three hospital, two dementia, one serviced apartment); eight nursing staff (three unit coordinators/registered nurses (RNs) in the rest home, hospital and dementia units, one unit coordinator/enrolled nurse (EN) in the serviced apartments, four staff RNs (two hospital, one dementia, one rest home; one chef; one maintenance; one housekeeper; one laundry; one gardener/health and safety officer; three activities staff (one diversional therapist and two activities coordinators) confirmed their understanding of the Code and how it relates to their job role and responsibilities.</p> <p>Interviews with eleven residents (six rest home and five hospital level) and twelve relatives (five hospital, one rest home and six dementia level) 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 provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all 11 resident files reviewed (three rest home- including one serviced apartment resident, five hospital, including one ACC resident and three dementia, including one DHB funded resident that was on respite). Permissions granted also form part of the admission agreement. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. There is evidence of GP discussions with the enduring power of attorney (EPOA) for residents deemed 'not competent' to make a resuscitation decision. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. The EPOA was activated in the dementia care files reviewed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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 provides opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks. Complainants are provided with information about the HDC advocacy service if resolution of the lodged complaint is not to their satisfaction.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. There is an on-site shop that is managed by volunteers. 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 the community. Relatives and friends are encouraged to be involved with the service.</p> <p>Links are in place with community services (eg, regular outings, men's club outings, external church services). Van outings occur regularly.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	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 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 complaints' 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). Fourteen complaints were lodged in the care centre in 2018 and six complaints have</p>

		<p>been lodged in 2019 (year to date). All complaints received were acknowledged, investigated and were documented as resolved. This includes one complaint lodged with the DHB (2018). Complainants are provided with information on how to escalate their complaint to the HDC advocacy service if resolution is not to their satisfaction.</p> <p>The complaints process is linked to the quality and risk management system. There is evidence of complaints received being discussed in staff (full facility) and management meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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 about the Code. Large print posters of the Code and advocacy information are displayed. The information pack is discussed 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.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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 involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process. This process includes family involvement. Interviews with residents confirmed their values and beliefs were considered.</p> <p>Caregivers interviewed described how choice is incorporated into the provision of resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and</p>	FA	<p>Ryman has a Māori health plan in place. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff attend cultural training and complete competencies around cultural safety. Links are in place with local iwi. A Māori staff member or a chaplain blesses rooms following the death of a resident.</p> <p>Entertainment includes a kapa haka group and celebration of Matariki. Family/whānau involvement is encouraged in the assessment and care planning process.</p> <p>Three residents (two dementia, one hospital) identified as Māori during the audit, but no residents were able</p>

beliefs.		to be interviewed. One file was reviewed of a resident who identifies as Māori. The resident's care plan identified the resident's Māori values and beliefs. One caregiver interviewed who identified as Māori, provided examples of how the service meets the needs of Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out with each new resident and their family. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if the resident's 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.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include roles and 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 address concerns as they arise. Interviews with two managers (village manager, clinical manger) and staff, confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data 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. A general practitioner (GP) visits residents three times per week. On-call GP services are in place twenty-four hours a day, seven days a week. Links are embedded with allied health professionals. In the selection of resident files reviewed, care plans reflected input from physiotherapy, dietetic, and podiatry services.

		<p>Implementation of the myRyman electronic resident management system has been very successful, although this system is not fully implemented yet.</p> <p>The service identified an area for improvement around reducing unnecessary admissions to hospital and increasing the number of “well” days for residents within their own environment with familiar staff and surroundings. In liaison with the DHB, the service has been successful reducing unnecessary admissions to hospital which has included the development of and the development of pathways to upskill RNs in clinical assessments and access to afterhours GP service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>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. This was evidenced in all 15 adverse events reviewed. 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 are available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Jane Mander is a Ryman healthcare retirement village located in Kamo, Whangarei. The care centre is modern and spacious. The facility is built across three floors with a design that includes a large atrium and courtyards. Jane Mander provides rest home, hospital and dementia levels of care for up to 142 residents. This includes 20 rest home level and 20 dual purpose (rest home or hospital) beds on the ground floor, 40 hospital level beds on the first floor, 32 dementia level beds on the second level (approved as one large secure unit by the DHB) and 30 serviced apartments that are certified to provide rest home level care. Occupancy during the audit was 113 (23 rest home level residents (including 3 in the serviced departments), 59 hospital level residents and 31 residents in the dementia unit. There were two (dementia level) residents on respite, one funded by the DHB. One (hospital level) resident was on ACC and the remaining residents were on the aged residential care contract.</p> <p>There is a documented service philosophy set at Ryman Christchurch, that guides the quality improvement and risk management programmes. Annual organisational objectives are documented with evidence of monthly reviews and reporting to Ryman Christchurch on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions on the progress towards meeting annual objectives.</p> <p>The village manager has been in the role for over two years. She has worked in the health industry for over 30 years and in the aged care sector for 20 years. In addition to her role as village manager, she is a Ryman regional manager for two other Ryman facilities. The village manager is supported by a clinical manager/RN, a hospital unit coordinator/RN (who fills the operational role at the village in the village</p>

		<p>manager's absence), an assistant to the manager and unit coordinators for the rest home (RN), dementia unit (RN) and serviced apartments (EN). The clinical manager has been in her role for two years. The management team have maintained at least eight hours each 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>	FA	<p>The village manager also works as a regional manager for two other Ryman facilities and is away five days a month with three additional days a month allocated to completing tasks unrelated to operations at Jane Mander. During her absence, the hospital unit coordinator is second in charge for village operations and a senior RN fills the hospital unit coordinator's role.</p> <p>The four unit-coordinators (one rest home/RN, one hospital/RN, one dementia/RN and one serviced apartment/EN) are responsible for clinical operations during the temporary absence of the clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Jane Mander 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 to the management team. Discussions with the managers and staff, and review of management and staff meeting minutes reflects their involvement in quality and risk management activities.</p> <p>Resident meetings are held two-monthly for the hospital, rest home and dementia units and relative meetings are held three-monthly. The frequency of family meetings have recently been increased to improve communications. The village manager and/or clinical manager attend these meetings and minutes are maintained. Resident and relative surveys are completed annually. When compared to other Ryman facilities, the 2019 results reflected a ranking of #3 for net promoter score and #14 overall.</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 and policies are developed, implemented and regularly reviewed, meeting sector standards and contractual requirements. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements.</p>

		<p>Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. The village manager visually conveys information through power point presentations during staff meetings, utilising graphs and videos for staff learning opportunities.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings. A health and safety officer (gardener) is appointed who has completed external (level four) 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 staff. 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 either reception or maintenance staff. All new staff and volunteers are inducted and orientated to the facility and are advised of the health and safety programme at this time. There is also annual health and safety in-service training. A significant number of health and safety quality improvements have been implemented. In particular, there has been a reduction in the number of manual handling adverse events over the past year that has resulted in a rating of continuous improvement.</p> <p>Falls prevention strategies are in place. Falls rates per 1000 bed nights are below the Ryman threshold in the rest home and a rating of continuous improvement has been awarded.</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, corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action(s) noted and any follow-up action(s) required. Pressure injuries are documented on a wound report in VCare.</p> <p>A review of 15 reports (eg, witnessed and unwitnessed falls) identified that all are fully completed and include follow-up by a registered nurse. Regular management meetings and informal meetings during the week provide an opportunity to review incidents as they occur. Neurological observations are completed if there is a suspected injury to the head (eg, unwitnessed falls).</p> <p>The village manager and clinical manager interviewed were able to identify situations that would be reported to statutory authorities. Evidence of notification to HealthCERT and the DHB were evidenced for one event that involved a police investigation (2018).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	FA	<p>There are comprehensive human resources (HR) policies, including recruitment, selection, orientation and staff training and development. Each staff HR file out of fourteen staff files reviewed (seven caregivers, two staff registered nurses, one-unit coordinator/RN, one laundry assistant, one housekeeper, one van driver,</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>and one physiotherapy assistant) included a signed contract, signed job description relevant to the role, police check, induction paperwork, application form, interview and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of nursing practising certificates is maintained within the facility. Practising 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 new employee's job role and responsibilities. Caregivers are required to complete competency 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.</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 annual competency questionnaires. Registered nurses are supported to maintain their professional competency. Sixteen of twenty-three registered nurses have completed their interRAI training. RNs and ENs attend journal club meetings. 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 procedures or treatments including (but not limited to) medication competencies and insulin competencies.</p> <p>Nineteen caregivers work in the dementia unit. Nine have completed their dementia qualification and nine are in the process of completing theirs within the acceptable timeframe of 18 months. One caregiver has yet to commence their training programme, but this is within the acceptable timeframe as per contractual requirements.</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</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/RN, assistant to the manager and clinical services manager/RN work full-time (Monday – Friday).</p> <p>The hospital wing (occupancy 39 hospital level residents) is staffed with a unit coordinator/RN Tuesday - Saturday. Two staff RNs cover the AM and 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 two long shift caregivers. One fluid assistant covers</p>

<p>providers.</p>		<p>the AM shift (short shift) seven days a week, a lounge carer covers the PM shift (short shift) and a physiotherapy assistant provides cover five days a week.</p> <p>The dementia unit (occupancy 31 residents) is staffed with a unit coordinator/RN on the AM shift Sunday – Thursday. A staff RN covers the AM shift on Friday and Saturday and an EN covers five days a week (Saturday – Wednesday). There are two long and two short caregivers. For the PM shift, a RN covers seven days a week with one long and two short caregivers and the night shift is staffed with either an EN or senior caregiver and two staff caregivers. A lounge carer is rostered on both the AM shift (0900 – 1230) and PM shift (1600 – 2000).</p> <p>The dual-purpose wing (occupancy 20 rest home level and 20 hospital level residents) is staffed with one unit coordinator/RN Sunday – Thursday and a staff RN on the two days that the unit coordinator is not available. The AM shift is staffed with a second RN and three long and three short caregivers. The PM shift is staffed with an RN, three long and two short caregivers and the night shift is staffed with an RN and two long shift caregivers.</p> <p>Serviced apartments (three rest home level) is staffed with one-unit coordinator/EN five days a week. A staff EN is rostered on the two days that the unit coordinator is not available. The AM is staffed with one long and four short shift caregivers. The PM is staffed with five short shift caregivers to 2100. After 2100, a designated caregiver in the dual-purpose wing covers the serviced apartments via a pager system.</p> <p>A ‘cover pool’ of staff (one RN 32 hours per week, two caregivers 72 hours per 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 reported that there are adequate staff numbers to assist residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are 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 services has been identified.</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>
<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 nurses, enrolled nurses and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (hospital, rest home, serviced apartments and dementia care). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart and signed on the back of the blister pack. 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 residents (one hospital and two rest home) self-medicating inhalers on the day of audit. Self-medication competencies had been completed by the RN and authorised by the GP and reviewed three-monthly. Emergency trolleys, oxygen and suction equipment is checked weekly.</p> <p>Twenty-two medication charts on the electronic medication system were reviewed (10 hospital, six rest home and six dementia care). Medications are reviewed at least three-monthly by the GP. 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 a chef/kitchen manager who oversees the food services. He is supported by two other chefs, cook assistants and kitchen assistants. All have current food safety certificates. The food control plan has been</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>verified and expires 15 October 2019. There is a well-equipped kitchen and all meals and baking are cooked on site. The introduction of project delicious, pure foods range for puree meals and nutritious smoothies has improved the quality and choice of meals and increased resident satisfaction in the dining experience. The four-weekly menu cycle is approved by a dietitian. The residents have a nutritional profile developed on admission which identifies dietary requirements and dislikes. This is reviewed six monthly as part of the care plan review. Residents order their meals a week in advance and staff assist where required. Breakfasts are served in each unit. The main meal is at midday. Meals are taken to the dining rooms in hot boxes, then transferred into a bain marie 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.</p> <p>A daily food control plan is completed for fridge, chiller and freezer temperatures, end cooked temperatures on all foods and incoming goods. A cleaning schedule is maintained. Internal audits are completed. Each unit delivers a "shopping" list if food items are required for their unit. Fruit platters, nutritious snacks, smoothies and sandwiches are delivered to the dementia care unit daily.</p> <p>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.</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 potential residents should this occur and communicates this to potential 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 gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All files reviewed evidenced that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments (part 1 and part 2) and relevant risk assessments had been completed on the myRyman system within 24-48 hours of admission for all residents entering the service including the respite care resident. First and routine six-monthly interRAI assessments had been completed for long-term residents including the resident under ACC. Applicable assessments are completed and reviewed at least six-monthly or when there is a change to residents' health/risk. The outcome of all assessments is reflected in the myRyman care plans developed</p>

		for all residents including respite care residents. Behaviour assessments and behaviour management plans had been completed for the three dementia care residents (including the respite care resident) with the outcomes and interventions documented in their myRyman 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 on myRyman evidenced multidisciplinary involvement in the care of the resident. All care plans are 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, potential behaviours, triggers, interventions and strategies for de-escalation including activities. 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, dietitian, wound care nurse and mental health services for older persons and community mental health nurse. 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 nurses interviewed stated 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 are updated (eg, changes to health, risks identified, infections and/or as per monitoring requirements).</p> <p>Care staff interviewed stated that there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessments, wound management and evaluation forms were documented electronically, and wound monitoring occurred as planned in the 19 wounds reviewed across the facility (skin tears, abrasions, lesions, laceration, ulcers, and one stage-two facility-acquired pressure injury). There are adequate pressure relieving devices available and care staff attend regular pressure injury prevention education. Caregivers document changes of position electronically. The hospital unit coordinator is the wound care champion and has attended wound management training. There is access to the district nursing wound nurse specialist on request.</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 (one qualified DT, two activity coordinators and one activity assistant) implement the 'Engage' activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. There is an activity coordinator based in the hospital five days a week with an activity assistant covering two days a week for the seven-day programme. The activity coordinator in the rest home provides a Monday to Friday programme with assistance from the activity assistant. The DT is based in the dementia care unit from Sunday to Thursday (0930 to 1800) with the activity assistant on Friday and Saturday.</p> <p>Residents have the choice of a variety of Engage activities within each unit in which to participate, including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, cooking, news and views, make and create, memory lane, walking group and happy hours. 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/chats to check if there are any activities they might like to attend. There are volunteers involved in one on one activities including chats, reading and pamper sessions.</p> <p>The service has a van for the regular outings for rest home, hospital and dementia care resident outings. Residents attend functions in the community such as the Alzheimer's club/dance, other rest homes and Kamo club. Community visitors to the units include entertainers, line dancers, kindergarten and school children and visiting pets. There are combined celebrations/events held in the large lounges and atrium for residents from all the units. Dementia care residents (as appropriate) join in the entertainment and other celebrations under supervision. There are interdenominational church services held in the chapel with room visits as required.</p> <p>The DT in the dementia care unit has been in the role three years. Engage activities are focused on meaningful activities and resident preferences. A sensory room has been set up with soft lighting, music, aromatherapy, and sensory items. This has been in place three months and offers a relaxing pace to de-escalate and re-direct residents from behaviours.</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 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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Six long-term resident care plans had been evaluated by the registered nurses six monthly or when changes to care occurs. Four residents (two rest home and two dementia care residents) have not been at the service long enough for an evaluation. The respite care resident does not require an evaluation of care.</p>

<p>comprehensive and timely manner.</p>		<p>The multidisciplinary (MDT) team review involves the RN, GP, CG and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are at least three-monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan and are invited to attend the MDT.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services was 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 geriatrician, mental health services for older people and dietitian. Referrals are made to the need's assessment team for re-assessment for level of care as evidenced for one resident re-assessed from rest home to dementia level of care and one resident from serviced apartment to rest home level of care. Discussions 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas or an external shed. 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. Staff were observed wearing personal protective clothing while carrying out their duties. Relevant staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility has three levels with stair and lift access. The building holds a current warrant of fitness which expires 20 December 2019. The maintenance manager works four days a week and is supported by a maintenance assistant. The maintenance manager oversees maintenance and grounds for the retirement village including the care centre. There is a maintenance request book in each unit which is checked daily and signed off when repairs have been completed. Contractors are available when required.</p> <p>There is a planned maintenance schedule which includes testing and tagging of electrical equipment, calibration of clinical equipment, annual check of all hoists and weigh scales and three-monthly hot water</p>

		<p>temperature monitoring and call bell audits.</p> <p>The communal areas and hallways are well maintained. The corridors are wide 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. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>The dementia unit (on the third level) has two secure outdoor areas with gardens, seating and shade. There is free indoor/outdoor access for residents with two entry/exits into the indoor 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 requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms 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 privacy signs on all toilet doors. There are communal toilets near communal areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There are large and small communal areas in all units. In the rest home there is a large main lounge and smaller lounge. Activities occur in the larger areas and the smaller areas are spaces where residents who</p>

<p>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>		<p>prefer quieter activities or visitors may sit. There is a family room with tea/coffee making facilities. The hospital unit has the same layout as the rest home. There are separate dining rooms and serveries in each area. The dementia unit has a separate dining room and lounge area. There is an additional quieter lounge area which families also use. There is a shop, café, hairdressing salon, beauty therapy room and chapel.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>CI</p>	<p>There are laundry and cleaning policies in place, safety data sheets and product information available to staff. There are designated cleaning and laundry staff. All laundry is done on site. The laundry is divided into a “dirty” and “clean” area with an entry and exit door. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system and monthly by the chemical provider. The cleaner’s equipment was attended at all times or the trolley locked away when not in use. All chemicals on the cleaners’ trolley 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 locked areas.</p> <p>The service identified a review of the laundry service was required following feedback from the 2017 survey and dissatisfaction with the laundry service in the 2018 survey. An improvement plan was implemented that has resulted in an increase in resident and relative satisfaction.</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. A defibrillator is in an easily accessible location that is known to staff.</p> <p>The care centre has an approved fire evacuation plan and fire drills six monthly. A virtual fire alarm is used instead of an actual fire alarm. Smoke alarms, a sprinkler system and exit signs are in place. The village has four emergency generators that are serviced by an external contractor. It also has 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 readily accessible civil defence kits 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. Alerts</p>

		<p>are sent electronically to staff for 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 and a selection of residents in the care centre have call bell pendants.</p> <p>Security contractors manage safety in the village from dusk to dawn. External security cameras and internal cameras in selected areas (eg, corridors) 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 comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately ventilated and heated, with under floor heating. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme are appropriate for the size and complexity of the service. The infection control and prevention officer is the clinical manager. A job description defines the role and responsibilities for infection control. 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 sanitisers 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</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 two years and attends annual infection control education including teleconference and on-line training. Management, clinical and facility meetings cover trends and the analyses of infections.</p> <p>The infection control officer has access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, district nurses, local laboratory and expertise from within the organisation.</p>

organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflect the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman facilities 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. Policies and procedures are available to staff through the on-line Ryman library.</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>	FA	<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. MyRyman care plans document infection precautions relevant to current infections or multi-resistant organisms. There are quick reference flip charts for infection control events located in the nursing stations.</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</p>	FA	<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 myRyman 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. The GP monitors the use of antibiotics. Staff are informed of infection control through the variety of facility meetings. Meeting minutes</p>

infection control programme.		<p>are made available to staff.</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, and any areas for improvement and education needs within the facility.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 ten residents (hospital level) who were using restraints (bedrails and chair briefs) and two residents (one hospital and one rest home) who voluntarily requested enablers (bedrails). One file was reviewed of a hospital level resident using an enabler (bedrail). An assessment was completed, the resident had given written consent for use of the enabler, risks were identified, and the use of the enabler was documented in the resident's care plan.</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.</p>
Standard 2.2.2: Assessment	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.</p>

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>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 reviewed of residents using a restraint (one bed rails, one chair brief). Completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<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 each resident's care plan. Internal audits, conducted six-monthly, measure staff compliance with 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>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The evaluation of restraint covers 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.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>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.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service identified an area for improvement around reducing unnecessary admissions to hospital and increasing the number of “well” days for residents within their own environment with familiar staff and surroundings. In liaison with the DHB, the service has been successful reducing unnecessary admissions to hospital which has included the development of and</p>	<p>In January 2018 Jane Mander began working in partnership with the DHB to improve outcomes for residents by increasing “well” days at home (within the care facility). The village manager took part in the multidisciplinary advisory working group and surveyed RNs in aged care which identified opportunities for upskilling RNs and has been involved in the development of pathways such as UTI, indwelling catheter issues and constipation. These step by step pathways (accessible on the DHB website) provide RNs with additional information and support. DHB registrars have provided on-site clinical skills training for the RNs. It was also identified that admissions were occurring due to poor planning around advance cares. Jane Mander has taken a pro-active approach to advance care planning and has provided education/information to residents and families with all residents/families in the care centre, independent living and townhouses. The GP (interviewed) confirms there is a discussion held with the resident (as appropriate) and families regarding end of life care, hospitalisation and resuscitation status (if there is no advance directive in place) on the admission visit. There are three GP visits a week and there are timely medical interventions implemented as required. The GP is available 24 hours. Symptom control for end of life care is timely and there are regular visits from the DHB hospice nurse to support the team, residents and</p>

		the development of pathways to upskill RNs in clinical assessments and access to afterhours GP service.	families. In 2017 there were 80 admissions to the emergency department and in 2018 there were 65 admissions evidencing a reduction of 18.75% on the prior year.
<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>The service has implemented a quality improvement activity around ensuring falls have reduced for rest home level residents. This has remained low for the 2019 year (below the Ryman set threshold).</p>	<p>Data collected and collated is 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 (but not limited to) falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; 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 is reviewed monthly and is regularly discussed at staff meetings. The outcome achieved continues to reflect that the number of falls per 1000 bed nights in the rest home is below the Ryman average with less than six falls per 1000 bed nights since September 2018. This is in contrast to as many as 18 falls in March 2018.</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This</p>	CI	<p>A health and safety programme is being implemented that reflects on quality improvement initiatives that have been undertaken by the service. In particular, the number of manual handling incidents from lifting bags of</p>	<p>Manual handling incidents related to waste removal have reduced from four to nil when comparing data over the last two fiscal years. The high number of back injuries prompted the purchase of a lifter that places bags of waste into rubbish bins. Procedures were introduced following the purchase of the lifter that eliminated the need for staff to manually lift the bags. Eighty-four percent of staff reported during evaluation of the lifter that using the lifter has made their job easier. A visual photograph reflected evidence of how the lifter reduces back strain.</p>

<p>shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>waste to place them in the rubbish bins have reduced significantly.</p>	
<p>Criterion 1.3.13.1 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. Resident and relative satisfaction has improved around the variety and choice of meals offered, temperature of meals and improved quality of modified/textured meals.</p>	<p>The four-week rotating project delicious 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. While the 2018 resident survey evidenced improvement from 2017, the service identified a further improvement was required due to feedback and complaints received around the temperature of meals, not receiving their choice of meal and quality of foods. The following was implemented</p> <p>a) The kitchen manager met with residents to review their individual dietary requirements and swapped the more unpopular food items with resident preferences; b) Liaised with suppliers to purchase high quality foods; c) Purchase of plate warmers and insulated lids for meals to rooms; d) Staff education around nutrition, serving and presentation of meals and dining etiquette; e) Additional time allocated to the hospital fluids assistant person to assist residents to fill in their weekly menu, so they receive meals of their choice; f) Pureed food smoothies of different flavours have been introduced providing extra nutritional value for resident with poor appetite; g) The purchase of pure foods for pureed meals providing additional nutritional value and a more palatable option.</p> <p>There has been a further improvement in resident satisfaction in meals from 4.06 in 2018 to 4.16 in 2019. Resident meeting minutes evidenced satisfaction in meals and the pure foods range. Increased satisfaction in meals is demonstrated in the improved ranking within the organisation from #21 in 2017 to #4 in 2019. The</p>

			service has been successful in providing excellence in food services.
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	<p>A review of the laundry service and remodelling of the laundry has led to an improved, efficient service and increased resident and relative satisfaction.</p>	<p>An action a was developed to improve the work flow and efficiency of the laundry service and reduce missing/unnamed clothing. This included meeting with relatives and residents to discuss a plan to try and improve the service. It was agreed to display unnamed clothing at relatives' meetings and weekly in the units. This has resulted in a number of garments being re-claimed. There is a labelling machine in the laundry and staff label all residents' personal items on admission and as required/claimed. Each resident has individually labelled purple laundry bags for their personal use. Baskets have been provided in ensuites for delicates/woollens for relatives who prefer to take these articles home for washing. The laundry has been remodelled for ease of workflow with new joinery and shelving which has improved the efficiency for folding and sorting of clothing into individually named baskets. There has been an improvement with a same day wash and return of clothing. Installation of air conditioning has improved the work environment reducing staff fatigue and improving productivity, evidenced in a staff survey. There has been an improvement in resident satisfaction results from 4.07 in 2018 to 4.52 in 2019. There has been an improvement in relative satisfaction form 3.45 in 2017 to 3.98 in July 2018. There were no unnamed clothing items on the day of audit. Laundry staff interviewed confirmed the number of missing clothing has greatly reduced and they are very satisfied with the new laundry layout/refurbishment which improves the efficiency of the service.</p>

End of the report.