

# **Essie Summers Retirement Village Limited - Essie Summers Retirement Village**

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## **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:** Essie Summers Retirement Village Limited

**Premises audited:** Essie Summers 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: 2 May 2019      End date: 3 May 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: 97**



# Executive summary of the audit

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## 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Essie Summers is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 125 residents. There were 97 residents at the time of the audit.

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

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

There was one area of improvement required around medications documentation.

Areas of continuous improvements were identified around good practice in palliative care, quality initiatives, activities, food services, restraint free and infection surveillance.

## 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.

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (eg, the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

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

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

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

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

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

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.

Some standards applicable to this service partially attained and of low risk.

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 demonstrated 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 meals 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.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There are spacious lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities. Resident rooms are spacious and allow for safe movement of staff and mobility equipment. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.
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The facility is restraint free for the last five years. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents assessed as requiring the use of restraint and no residents required an enabler. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		All standards applicable to this service fully attained with some standards exceeded.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	5	39	0	1	0	0	0
Criteria	6	86	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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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
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Ryman policies and procedures are being implemented that align with the requirements of the 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 care staff (nine caregivers, two unit coordinators/registered nurses (RNs), seven RNs and three activities officers) confirmed their understanding of the Code. Staff could provide examples of how the Code applies to their job role and responsibilities. Six residents interviewed (four rest home and two hospital level) and 10 relatives (one rest home, six hospital and three dementia unit) confirmed that staff respect privacy and support residents in making choices where able.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need	FA	The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all ten resident files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. All residents in the dementia unit have activated EPOAs. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent.

to make informed choices and give informed consent.		
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents 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. Advocacy information with contact details are displayed throughout the facility. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain actively involved in community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  A complaint register (for each service level) includes written and verbal complaints, dates and actions taken. The village manager investigates complaints in consultation with the clinical manager. Escalation of complaints is dependent on the severity of the complaint. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). Six complaints had been lodged in 2018 and two complaints to date for 2019. There is evidence of complaints received being discussed in management meetings and staff meetings. All complaints received were investigated to the satisfaction of the complainant.  Complainants are provided with information on how to escalate their complaint if resolution is not to their

		satisfaction.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	<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 around the Code. Large print posters of the Code and advocacy information are displayed. The village manager or the clinical manager discuss the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment of items not included in the scope. This is included in the service agreement.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>A tour of the facility confirmed there were areas that support personal privacy for residents. All rooms are single. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involved residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p> <p>Interviews with caregivers described how choice is incorporated into resident care provision.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. A letter of invitation has been sent to local iwi to meet with resident and staff. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. A school kapa haka group have performed on occasions. Care staff interviewed confirmed care plans record any cultural needs in the myRyman care plan. At the time of the audit, no residents identified as Māori.</p>

beliefs.		
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 the resident and/or whānau as appropriate. Individual beliefs or values are further discussed and incorporated into the myRyman care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their cultural values and beliefs. Residents are supported to attend church services of their choice.
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. Staff sign a code of conduct/house rules and professional boundaries policies and procedures during their induction to the facility. The monthly full facility meetings include discussions on professional boundaries and concerns as they arise. Interviews with two managers (village manager and clinical manger) and staff, confirmed their awareness of professional boundaries and scope of practice.
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 through facility meetings and a staff newsletter "Essentials". Practice is evidence-based. Registered nurses participate in the RN journal club. Registered nurses are supported to maintain their professional competency and undertake postgraduate education. Currently there are four RNs involved in external training including certificate in palliative care, certificate in gerontology, pressure injury prevention link nurse and CDHB

		<p>NetP programme. Links are embedded with allied health professionals.</p> <p>The service receives referrals for palliative and end of life residents and have received very positive feedback from the families and health professionals on the quality of care provided.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	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. Twenty-five incidents reviewed across the levels of care (for March 2019) met this requirement. Family members interviewed confirmed they are promptly notified following a change of health status of their family member. Care centre relative meetings are held six monthly May and December. In the December meeting relatives were invited to a dinner and meeting where survey results were also discussed. The monthly newsletter "Care Connection" is sent out to families.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. Care staff interviewed could describe strategies for communication with residents of other ethnicities including using body language.</p>
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Essie Summers is a Ryman healthcare retirement village. The facility is built across three floors. It provides rest home, hospital and dementia levels of care for up to 125 residents. This includes 30 serviced apartments certified to provide rest home level care, 30 rest home level beds, 41 hospital level beds, and 24 dementia level beds. There are no dual-purpose beds. Occupancy during the audit was 97 residents. There are 34 rest home residents (including one respite care and five rest home residents in serviced apartments), 39 hospital level residents (including one resident under the serious medical illness (SMI) contract and one resident on the end of life (EOL) contract), and 24 dementia level of care residents. All other residents were under the ARCC.</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values and beliefs are documented that are specific to Ryman Essie Summers. The 2018 village objectives have been reviewed and service has achieved goals including increased staff attendance at training and increased resident/relative satisfaction survey results. The 2019 objectives/goals set, include upskilling of staff, reduction of medication errors, reduction of staff incidents and improved comfort seating for residents. The clinical manager is on the Ryman Medication Advisory committee. There is quarterly reporting on progress to the regional operations manager and head office.</p> <p>The village manager has been in the role for 12 years and is also a registered nurse (RN) with a current practicing certificate. She is supported by a clinical manager who has been in the role five years, an assistant manager and regional operations manager who was present on the days of audit.</p> <p>The village manager has maintained at least eight hours of professional development within the last year related to managing an aged care facility including civil defence management, health and safety (contractors on site), culture</p>

		<p>in residential care and has attended the Ryman conference and village managers training day.</p> <p>The clinical manager has attended at least eight hours of professional development including clinical and management training such as falls prevention management, complaints management, end of life care, pressure injury prevention and has attended the Ryman two-day conference.</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 assistant manager and clinical manager are responsible during the temporary absence of the village manager. The unit coordinators/RNs are responsible for clinical operations during the temporary absence of the clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management 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>Essie Summers has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance is reported at the weekly management meetings and also to the organisation's management team. Quality data, quality initiatives and corrective action plans are discussed at the monthly full facility meetings, clinical meetings and other facility meetings held across the site. Meeting minutes are made available to staff. Discussions with the managers and staff and review of management and staff meeting minutes, demonstrates their involvement in quality and risk management activities.</p> <p>Resident meetings are held regularly in each unit. Relative meetings are held six monthly. The village manager attends the meetings and minutes are maintained. Resident and relative surveys are completed annually. Results for the February 2019 survey reflected improvements compared to 2017 in all areas. There has been a greater increase in resident satisfaction around care, communication, food and activities. Essie Summers now ranks #1 for meals across the Ryman group. Survey results are communicated to residents, relatives and staff through meetings.</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 and staff</p>

		<p>interviews.</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 is an internal auditing programme set out by head office. The service develops a corrective action plan for any audit result below 90%. A quality improvement register is maintained. Corrective actions are signed off when completed and audit results are communicated at the management and facility meetings.</p> <p>The facility has implemented processes to collect, analyse and evaluate data including resident and staff accident/incidents, hazards, infections, complaints and audit outcomes, which is utilised for service improvements. There has been a downward trend in falls, skin tears and challenging behaviours that has been maintained below the group average key performance indicators (KPI) over the last year. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety (and infection control) committee meetings. A health and safety officer (plus fire officer and physiotherapy assistant) has completed level four health and safety training. Risk management, hazard control and emergency policies are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The hazard register has been reviewed annually and includes hazard control plans for each area of work. All contractors are inducted to health and safety processes. All new staff are inducted and orientated to the facility and are advised of the health and safety programme. There is a focus on reducing staff incidents for 2019 which includes monthly safe manual handling in services, health and safety focus group discussions and Ryman "moves" (stretching exercises) prior to commencing work. The health and safety officer is a representative on the Safer together forum at head office. The organisation promotes staff wellness. The staff room has been refurbished and is bright with doors that open for fresh air. A fruit bowl is replenished daily and there is a treadmill and massage chair for use. The noticeboard keeps staff informed on health and safety, infection control and meetings. Care staff felt valued and supported by management and the organisation. The regional operations manager (interviewed) informed that while there has always been a Ryman help line available for staff, there has been a further helpline and counselling service readily accessible for staff affected (directly and indirectly) by the Christchurch tragedy.</p> <p>Individual falls prevention strategies are in for residents identified at risk of falls. The service contract a physiotherapist six hours a week who is supported by an employed physiotherapy assistant to carry out exercises and walks as directed by the physiotherapist. Care staff interviewed could describe falls prevention strategies as documented in myRyman care plans.</p>
Standard 1.2.4: Adverse Event	FA	There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident reports are completed

<p>Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>electronically on VCare for each incident/accident with immediate action noted, relative notification and any follow-up action required.</p> <p>A review of 23 incident/accident reports (witnessed and unwitnessed falls, skin tears, challenging behaviours) for March 2019 were reviewed and identified that all were fully completed and include follow-up by a registered nurse. The unit coordinators and managers are involved in the adverse event process with the regular management meetings and informal meetings during the week providing an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager are able to identify situations that would be reported to statutory authorities. There have been four Section 31 notifications for 2019 to date for four stage three pressure injuries (two on admission and two facility acquired). There have been no outbreaks to report.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (one-unit coordinator, three registered nurses, four caregivers, one activities coordinator, one health and safety officer/fire officer/physiotherapy assistant and one head chef), contained all the required employment documents including job descriptions and completed orientations specific to their role. An eight-week post-employment assessment is completed and annually thereafter. The assistant manager maintains staff files, records of annual practicing certificates for RNs, enrolled nurses and other health practitioners. All work visas sighted are valid.</p> <p>A general orientation programme for all staff is completed on-line and covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. Attendance at in-service has increased due to small group sessions "closing the loop" offered to those who were unable to attend the main session. Tool box talks occur to update/refresh staff on topics of importance. Comprehension questionnaires and competencies (relevant to the roles) are completed annually. Four of 13 registered nurses have completed their interRAI training.</p> <p>There were 20 caregivers working in the dementia unit. All 20 had completed dementia unit standards.</p> <p>There four staff currently progressing through diversional therapy qualifications.</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>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, assistant manager and clinical manager/RN work Monday – Friday. The unit coordinators for rest home and dementia care work Tuesday to Saturday and the hospital unit coordinator and service apartment coordinator from Sunday to Thursday. Currently there is a vacancy for a rest home coordinator with a pending appointment. In the interim a senior RN is covering the position. The RN in the hospital provides support to the rest home and serviced apartments as required.</p> <p>There are no dual-purpose beds. The units are as follows:</p> <p>Rest home unit of 30 beds (with 27 residents on the day of audit) has on morning shifts; a RN seven days, two caregivers on the full shift and one caregiver 0700 to 1300. On afternoons there is one caregiver on full shift and two caregivers until 2100. There are two caregivers on night shift.</p> <p>Serviced apartments with five rest home residents and one rest home respite care on the day of audit): There is a senior caregiver who covers the serviced apartment days off. There are two caregivers on the morning (one 0800 to 1510 and one from 0700 to 1300) and two caregivers on the afternoon shift (one 1600 to 2100 and the other until 1900).</p> <p>Dementia care unit of 24 beds (with 24 residents on day of audit): A RN covers the unit coordinator days off. There are two caregivers on the full morning shift with a third on duty until 1100. There are two caregivers on the full afternoon shift and one caregiver on duty until 2030. They are supported by a lounge carer from 1630 to 2100. The activities coordinator is on duty from 0930 to 1800.</p> <p>Hospital unit of 41 beds (with 39 hospital level and one rest home resident on the day of audit): The hospital unit is divided into two units North with 21 beds and South with 20 beds. The units are both staffed with a RN on the morning and afternoon shift. There is a fluids assistant from 0930 to 1200. There are nine hours allocated to interRAI assessments. Each unit has four caregivers on morning shift (two full shifts and two finishing at 1300); four caregivers on the afternoon shift (two full shift and two finishing at 2100). They are supported by a lounge carer from 1600 to 2000. There is an RN and two caregivers on night shift.</p> <p>Each unit has designated activities coordinator(s) and housekeeping staff.</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. There is a cover pool of staff to replace for staff sickness and annual leave. Residents and family members interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files (both hard copy</p>

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>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 residents under serious medical illness and the end of life) 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</p>	PA Low	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered 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 special care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk supply order is maintained for</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>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 two hospital level residents self-medicating on the day of audit. Medications were stored safely in the resident's rooms. Three monthly self-medication competencies had been completed by the RN and authorised by the GP.</p> <p>There were no standing orders. There were no vaccines stored on site.</p> <p>Twenty medication charts on the electronic medication system were reviewed (ten hospital, six rest home and four dementia care). Medications are reviewed at least three monthly by the GP. The GP and the community mental health nurse review medications for dementia care residents. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. Medication administration observed, complied with policy.</p> <p>All controlled drug medications are documented in the register, however, not all times of administration were recorded.</p>
<p>Standard 1.3.13: 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>	CI	<p>The head chef and a second cook are supported by morning and afternoon kitchenhands. All have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. The food control plan has been verified with an expiry date of May 2020. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits.</p> <p>There is a well-equipped kitchen and all meals are cooked on site. Meals are taken to the dining rooms in hot boxes, then transferred into bain maries and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder and on a whiteboard. There are snacks available at all times in the dementia unit. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were very satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys. Management liaise regularly with the head chef to monitor feedback and identify any areas for improvement. Project 'delicious', offering variety and choice is implemented at Essie Summers. The service has expanded on project delicious with additional interventions which have exceeded the standard in improving resident nutrition.</p>

Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to prospective residents should this occur and communicates this to prospective 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.
Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the VCare system within 24-48 hours of admission for all residents entering the service including short-stay residents. InterRAI assessments had been completed for all long-term residents whose files were reviewed. Applicable VCare 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 plan. Behaviour assessments had been completed for the files of two dementia care residents with the outcomes included in the care plan.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed, evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs, resident goals and provide detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. All myRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice clinical nurse specialist, dietitian, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.

<p><b>Standard 1.3.6:</b> Service Delivery/Interventions  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 have been updated as residents' needs changed.</p> <p>The myRyman electronic system triggers alerts staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual electronic tablets in each resident room allows the caregiver the opportunity to sign the task has been completed, (eg, resident turns, fluids given).</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed, a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. Four chronic ulcers have had input from the GP. There are currently five pressure injuries including one grade one, three grade threes and one unstageable facility acquired. There are also surgical wounds, skin tears, and lesions receiving treatment. There is evidence of district nurse referrals for input into wound management. There has been input from the GP and wound care nurse specialist as required. Photos of wounds demonstrate healing progress with improvement. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically.</p> <p>Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
<p><b>Standard 1.3.7:</b> Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	CI	<p>A team of activity officers (one qualified diversional therapist – DT and three staff in training), and lounge carers, implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The activity officers work Monday to Friday in each of the five wings and are supported in the hospital and dementia units by afternoon lounge carers and a weekend activity team. The rest home programme is Monday to Friday and the hospital and dementia units are seven days a week.</p> <p>There is a weekly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of Engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside.</p>

needs, age, culture, and the setting of the service.		<p>The rest home residents in serviced apartments can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. Village friends visit regularly and volunteer time with residents including chats, reading and pamper sessions. The service hires a mobility van for hospital outings. The service has a van for the rest home, dementia care and mobile hospital resident outings. There are regular combined activities and celebrations held in the large lounges and atrium for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision.</p> <p>Activities in the dementia care units include triple A exercises, supervised walking groups, singing and karaoke, happy hours, adult colouring, make and create, sensory time and this week in history. The activity officer is on duty from 9.30 am to 6.00 pm and a lounge carer is on duty from 4.00 pm to 7.00 pm. Resources are plentiful. Volunteers include the twice weekly dog visits and a ukulele player.</p> <p>There are interdenominational church services held on a rotational basis. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated. Kindergarten children, babies and pets visit.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents' past hobbies and present interests, career and family. Resident files reviewed 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><b>Standard 1.3.8: Evaluation</b> Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Five long-term resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Four residents (two hospital, one rest home and one dementia care resident) have not been at the service long enough for an evaluation. The respite care resident does not require an evaluation of care. The RN completes a daily evaluation for respite residents. The multidisciplinary review involves the RN, GP, caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one - three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal)</b></p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, geriatrician, mental health services for older people, dermatology and dietitian. Discussion with the registered nurses identified that the service</p>

And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building holds a current warrant of fitness which expires 1 July 2019. There is a full-time maintenance manager who provides an after-hours on call service. Contractors are available when required.  Electrical equipment has been tested and tagged. The hoists and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained as were the indoor atrium and courtyards. There is an upstairs outdoor balcony area as well. All outdoor areas have seating and shade. The dementia unit garden is

for their purpose.		<p>safely fenced There is safe access to all communal areas.</p> <p>The service strives to maintain a safe and attractive environment for residents, staff and visitors. Essie Summers achieved recognition with the Christchurch City Council Garden award in 2017 and 2018, the Christchurch beautifying garden competition award in 2017 and 2018 and the Merrivale Retirement village award in 2018. In 2018 Essie Summers ranked 7th on the Ryman resident survey results. In 2019 they ranked 6th out of 31 Ryman villages.</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 within the facility have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are mobility toilets near all communal lounges. There are privacy signs on all toilet doors. Rest home and hospital residents interviewed confirmed staff respected their privacy when carrying out hygiene cares.</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</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>

setting.		
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and small communal areas. Activities occur in the larger areas, and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are dining rooms in each area. There is a shop, and hairdressing salon.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are documented systems for monitoring the effectiveness and compliance with the service's policies and procedures. There is a separate laundry area where all laundry is completed. The laundry is divided into a 'dirty' and 'clean' area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaners' trolley sighted were labelled. Manufacturer's data safety charts are readily available. There is a sluice room on each floor for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept locked when not in use. Internal audits and the chemical providers monthly audits monitor the cleaning and laundry service. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the facility.
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security	FA	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. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings. The village has an approved fire evacuation plan and fire drills six monthly. The fire officer provides fire warden training and staff induction to fire safety and emergency procedures on employment. The service has a diesel-powered generator on site which automatically starts in the event of a power outage. There are adequate food and water supplies (water tanks). There are civil defence kits (checked monthly) in each unit that contain radio, batteries, torches and other equipment.  Electronic call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms. Call bells and sensor

situations.		<p>mat function is checked annually. The call bell system has been upgraded to escalate to the RN, unit coordinators and clinical manager. Staff carry out security checks on the afternoon and night shifts which are documented in the handover book. The service has reinstated a security gate at another entrance for added security. There are two unscheduled security firm rounds each night.</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>All resident bedrooms have external windows with plenty of natural sunlight. The facility is heated, and windows open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Family interviewed stated the environment is comfortable.</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 is appropriate for the size and complexity of the service. The infection control and prevention officer (unit coordinator based in the dementia care unit) and the clinical manager share the role and responsibility for collation and analysis of infections across the facility. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets twice monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine with an increase in vaccinations for residents (97%) and staff (90%) for 2019. Hand sanitiser are placed appropriately within the facility.</p>
Standard 3.2: Implementing the infection control	FA	<p>The infection prevention and control committee (combined with the health and safety committee) meet twice monthly. The infection control officer has been in the role since 2017 and has attended external infection control education. The infection control officer enters monthly infection rates into the VCare register. The clinical manager collates</p>

<p>programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>information and provides reports to the committee, management and facility meetings including trends and analysis of infections.</p> <p>The infection and prevention officer has access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection 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 reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</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. Staff complete an infection control comprehension questionnaire. Infection control is an agenda item on the full facility and clinical meeting agenda.</p>

infection control to all service providers, support staff, and consumers.		Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	CI	<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 VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the clinical manager completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There have been no outbreaks since the last audit.</p>
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	CI	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>During the audit, there were no residents using enablers and no residents with restraints. The organisation has been restraint free since 2015 resulting in a rating of continuous improvement. The restraint officer (hospital unit coordinator) provides staff training is in place around restraint minimisation and de-escalation of challenging behaviours.</p>

## Specific results for criterion where corrective actions are required

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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Controlled medications were stored securely. Two medication competent staff checked the medications out, however, the time of administration was not always recorded.	The times of controlled drug administration were not recorded in the CD register on two occasions in both the rest home and hospital units (noting they were documented in the medication signing chart and therefore the risk has been identified as low).	Ensure the times of controlled drug administration are recorded in the register as per legislative requirements.  60 days

# Specific results for criterion where a continuous improvement has been recorded

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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
Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service is committed to providing best of care to palliative and end of life (EOL) care residents. Positive feedback from families and allied health professionals' evidence the service has achieved its aim to provide a holistic approach to EOL care including consultation with	<p>The aim of the service is to ensure that EOL residents receive optimum comfort in a supportive environment, full involvement and consultation with resident and the family and to ensure staff are confident in delivering bedside nursing to EOL residents. Interventions included developing a stronger partnership with hospice, hands on training for hospital care staff including caregivers buddying with RNs, all care staff attended fundamentals of palliative care modules, providing a soothing and calm environment including diffusers and music in the room and offering services (food and comfort for overnight stays) for family. The palliative care nurse (interviewed) visits one to three times a week offering support for staff, resident and family with a focus on symptom control. The Te Ara Whakapiri pathway has been implemented.</p> <p>There have been 17 referrals from hospice, community and acute care for palliative/EOL care. The service has achieved its goal to provide best palliative care. Evidence has been gathered by way of feedback from one family member (interviewed) and written cards and letters of thanks from families (sighted) including very positive feedback from a Māori resident. The palliative care nurse (interviewed) stated the staff are fantastic with the residents and families. In December the service held a Reflections ceremony for the families of residents who had passed away during the year. This time gave families an opportunity to share their memories and their grief.</p>

		families, hospice and specialists.	Correspondence from hospice confirms the working relationship between hospice and Essie Summers has been strengthened. Hospice has a high level of confidence in the palliative/EOL care that is provided by staff at Essie Summers.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Data collected and collated for falls across the hospital and dementia care unit evidence falls have remained below the group average over the last year. The number of skin tears have also reduced as falls have reduced. Challenging behaviours in the dementia care unit have reduced over the past year due to the introduction of a number of successful interventions.	<p>Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable organisational limits. Three quality improvement projects implemented in January 2018 were; reduction of falls, reduction of skin tears and reduction of challenging behaviours.</p> <p>1) Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: highlighting residents at risk, GP assessment for underlying causes, physiotherapy assessments and development of mobility plans, review of the residents environment, ensuring the residents mobility plan is current, lounge carer in the hospital and dementia units, implement falls prevention equipment such as sensor mats, wall sensors in rooms, improve nutrition and hydration, high protein smoothies to build muscle mass, intentional rounding and staff education. Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly and is regularly discussed at staff meetings. A review of the data evidenced that the falls rate is below the Ryman benchmarked target (10/1000 bed nights) for both hospital and dementia care level residents. For hospital level residents, the average rate was 5/1000 bed nights (April 2018 – April 2019) and for dementia level residents the average number of falls is 5-6/1000 bed nights (Apr 2018 – April 2019). A spike in data in November to December 2018 was explained with actions taken.</p> <p>2) The incidence of skin tears across the care centre have continued to decrease from 2017 due to promoting good skin integrity with regular moisturizing, use of limb protectors for residents with frail skin and waterlow assessment above 20, prevention of falls and safe manual handling training for staff. Skin tears have reduced as falls have reduced. Skin integrity has improved, and resident outcomes have improved by preventing discomfort with skin tears and reduced complications such as infections. Skin tears in 2017 were 297 and in 2018 was 204. To date for the first quarter of 2019 there has been a total of 38 skin tears which evidences a downward trend.</p> <p>3) Challenging behaviours have reduced in 2018 – 2019 due to new interventions and introduction of new activities in the dementia care unit (link CI 1.3.7), including extending the lounge carer programme to 9 pm, introduction of art classes, Plunket and kindergarten groups, staff development, decrease in UTIs, review of antipsychotic medications, food and fluid readily available “food on the run”. Challenging behaviour incidents have remained below the group</p>

			average for the past year. One spike in the November 2018 was related to one recently admitted resident to the dementia care unit. Interventions including activities were successful in de-escalating behaviours.
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.	CI	Ryman has introduced a number of systems to ensure residents nutritional needs are met and the dining experience improved. This has been achieved with the further enhancement to project 'delicious' with an emphasis on improving resident nutrition and maintaining healthy and stable weights.	<p>An action plan was first developed in 2017 that included introduction of food on the run. The service recognised that more could be done to prevent weight loss, increase resident enjoyment of meals and enhance the meal service. A new menu with three options for the main meal and two options for the tea meal was introduced. The head chef at Essie Summers is involved in menu and recipe development at an organisation level and is trialling improvements including flavour, texture and presentation. Pure foods have been introduced for fortified and puree meals. Feedback and recommendations from residents are discussed in the weekly management meetings and implemented.</p> <p>The dining room meal service was reviewed by a staff member with experience in hospitality. The review resulted in the implementation of floral arrangements on the tables, condiments on the tables, selected background music and staff education on dining room etiquette. The unit coordinators assist in the unit serveries and monitor the meal service.</p> <p>Residents at risk of weight loss were identified at clinical meetings and fortified meals (including soups, protein deserts and smoothies) were routinely provided to these residents. A programme to improve oral health was introduced for all residents. This involved staff education, use of oral mouth gel for residents with dry mouth and dysphagia, external oral care where indicated and an oral care regime to improve mouth moisture and food intake. All residents at risk were commenced on weekly weighs and food and fluid intake monitoring</p> <p>As a result of these interventions there has been an improvement in resident satisfaction evidenced through meeting minutes, comments in the communication book in the dining rooms, letters and cards written to the chefs/cooks (sighted), positive feedback at resident meetings (sighted), some residents gaining weight since project delicious commenced and residents sitting longer over their meals.</p> <p>The resident/relative satisfaction survey for 2018 demonstrated an increase in satisfaction with meals and the meal service. There have been no complaints in relation to food in 2018 and 2019 to date.</p>
Criterion 1.3.7.1 Activities are	CI	In January 2018, Essie Summers	In January 2018, the special care unit identified the benefits of resident interaction with young children and implemented a regular programme to promote positive engagement. A regular

<p>planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>activities team identified an opportunity to improve inter-generational activities. The plan was implemented as a result of recommendations from a research article. The service introduced a number of initiatives which were effective in decreasing challenging behaviours in the dementia unit and promoting a sense of self-worth.</p> <p>A second initiative was to implement art therapy in the special care unit. Research suggests that areas of creativity and creative expression are the last to be affected by dementia and staff sought to provide a medium for residents to express themselves. The programme has</p>	<p>Plunket group and kindergarten meets each week in the special care unit. The service provides equipment and activities that are child friendly but also suitable for the residents. The introduction of pre-school playgroups, kindergarten and Plunket visits has been successful in reducing behaviours and development of meaningful engagement between residents and children. On the day of audit residents were viewed playing games and joining music activities. An email from a local kindergarten confirmed the children's enjoyment of colouring in activities, residents reading and talking to the children and sharing afternoon tea with the residents.</p> <p>Essie Summers introduced the art project in the special care unit as a way of engaging the residents in purposeful and meaningful activities and promoting a means for the residents to express themselves. The project plan was commenced in June 2016 with the scheduling of weekly sessions. The service provided art supplies and ensured a supportive environment with a dedicated convener and support staff. Participation has been strong and consistent with 42% of residents regularly engaged. Significant therapeutic benefits have been observed including improved articulation and concentration, less agitation and greater social interaction and engagement. Residents who have been reluctant to engage in any other activities are engaging in the art class and show pride in their achievements. In 2017, the finished art works were professionally framed and displayed in the serviced apartments for four days before being relocated to the special care unit for the official exhibition. Art works have also been displayed at the Christchurch South Library. A black-tie event with next of kin and family invited to attend is held in December each year with the framed art works available for sale. This event was attended by 70% of the residents next of kin. Essie Summers special care unit has improved family survey results and in 2018 was ranked 5th out of 31 Ryman facilities. Overall satisfaction with the special care unit activities programme has increased 100% in July 2018 from the previous survey in March 2017. Interviews with staff and relatives confirmed the resident's enjoyment of the art therapy programme.</p>
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		resulted in positive benefits.	
Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	In February 2018 a project was identified to reduce urinary tract infections (UTI) following a spike in UTIs across the three levels of care. The service has been successful in reducing UTIs in each resident group across the care centre.	The infection control coordinator (RN) developed a project action plan for the reduction of UTIs in consultation with the infection control committee. The action plan included increasing fluids and maintaining a fluid intake record for all resident diagnosed with UTI, additional fluids in a variety of ways, yoghurt therapy (offered to all residents at various times and forms during the day), pure food high protein smoothie, ice blocks and jellies, treating UTIs symptomatically and not reliant on laboratory specimens, toileting schedules, regular staff UTI education, communication and infection statistics discussed and analysed for areas of improvement. The GP liaises with the service in the management of all UTIs. The service has been successful in reducing the incidence of UTIs February 2018 to April 2019. As a result, there has been less use of antibiotics, less untoward effects of UTI therefore reduced hospitalisation and better quality of life for residents. The service has been successful in reducing the incidence of UTIs below the group average from March 2018 to February 2019. A spike to five UTIs in March 2019 was explained with nosocomial infection and one suspected infection and the UTI rates have remained below the group average of 3 to date.
Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and	CI	There have been no enablers and no restraints in the facility since 2015. The service has been successful in maintaining a restraint free environment.	There were no residents who required an enabler no residents who required the use of a restraint. The restraint coordinator and restraint committee meet twice a year to review and evaluate policies and procedures and analyse the management of behaviours. Internal audits on restraint minimisation occur. Staff are provided education on restraint, the risks and intervention strategies. Strategies implemented to minimise the use of restraint include mandatory staff education and training that includes staff competencies, encouraging residents at risk to not remain in their room, lounge carers, anticipating resident's needs (eg, toileting) and intentional rounding of residents at risk.  Residents and families are well informed regarding the service goal of maintaining a restraint free facility and the benefits for the residents. The restraint free environment has not been impacted by resident falls or challenging behaviour incidents (link CI 1.2.3.6).

safety.			
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End of the report.