

# Bert Sutcliffe Retirement Village Limited - Bert Sutcliffe Retirement Village

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bert Sutcliffe Retirement Village Limited
<b>Premises audited:</b>	Bert Sutcliffe Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 16 September 2019    End date: 17 September 2019
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	122



# 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

Bert Sutcliffe 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 150 residents. There were 122 residents at the time of the audit.

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

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

There were no areas for improvement identified at this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

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 are resident and family meetings held and newsletters to keep residents and families informed.

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 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 with ongoing quality improvement initiatives. 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 study days at the DHB.

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.		Standards applicable to this service fully attained.
--	--	--

The registered nurses' complete assessments, care plan development and evaluations within the required timeframe. Care plans demonstrated service integration. Monitoring forms were being utilised. Care plans were updated for changes in health status. Resident and family interviewed confirmed they were involved in the care plan process and review.

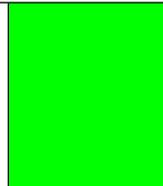
The activity team provides an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community. There were 24-hour activity plans for residents in the dementia care unit that were individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. Medication is appropriately stored, managed, administered and documented.

All meals are prepared on site. A dietitian designs the menu at an organisational level. Individual and special dietary needs are catered for. Nutritional snacks are available 24-hours for residents in the dementia care unit. Residents interviewed responded favourably to the food provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

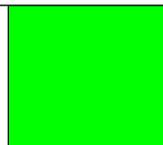


Standards applicable to this service fully attained.

The building has a current building code of compliance. There is a preventative and planned maintenance schedule in place.

## Restraint minimisation and safe practice

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



Standards applicable to this service fully attained.

The facility is restraint free for the last three years. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers should these be required. 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.

Standards applicable to this service fully attained.

The infection control officer (clinical manager) is responsible for coordinating/collating infection events across the service. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infection control data is communicated to all staff. 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)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>The village manager investigates complaints in consultation with the clinical manager. Escalation of complaints to the regional manager is dependent on the severity of the complaint. A complaint register (in hard copy and on the electronic system) is maintained for all written and verbal complaints with dates acknowledged, actions taken, investigation and letters of outcomes or face-to-face meetings with the complainants. Complaints are being managed in a timely manner and within timeframes determined by the Health and Disability Commissioner (HDC). Six complaints had been lodged in 2018. There have been ten verbal concerns and six written 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.</p> <p>One HDC complaint in March 2018 was investigated by the HDC and closed off with no further action.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>There is an open disclosure policy and management operate an open-door policy. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>record family notification when entering an incident into the database. Fifteen incidents reviewed across the levels of care (for August 2019) met this requirement. Three family members interviewed (of one rest home, one hospital and one dementia care resident) confirmed they are promptly notified following a change of health status of their family member. Care centre rest home and hospital resident meetings are held two monthly. Relative meetings are held in each unit six monthly. Results of surveys are communicated to the participants through the meetings. The HDC advocate attends resident and relative meetings on an annual basis. Residents and relatives are kept informed on village and care centre events/facility matters through the monthly village connection newsletter. There is a weekly newsletter published by the unit activity coordinator that is displayed in the rest home and hospital. A relative has commenced (January 2019) dementia support group meetings that are held regularly in the café.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Bert Sutcliffe is a Ryman healthcare retirement village. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care for up to 150 residents. This includes 30 serviced apartments that are certified to provide rest home level care. On level 5 (ground level) is the main entrance, reception and serviced apartments. On level 4 there are 41 dual-purpose beds with 39 rest home residents on the day of audit. On level 3 there is a 41-bed hospital unit with 40 hospital level residents (including one under ACC) on the day of audit. On level 2 there are two 19 bed dementia care units with 17 residents in each unit on the day of audit. There were nine rest home residents in serviced apartments (which are across levels 1,5,6,7,8, and 9). On the day of audit there were 122 residents.</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 Bert Sutcliffe. The village objectives are reviewed quarterly and progress reported to head office. There are weekly management meetings. The village manager reports to the regional manager who was present on day one of the audit.</p> <p>The village manager (non-clinical) has been in the role since the village opened in October 2016. She has a business management degree and is experienced in aged care management. She has attended over eight hours annually of professional development activities relating to managing a retirement village including attending the Ryman leadership training May 2019 and attends the Waitemata DHB primary health connections forum. The village manager is supported by a regional manager, an assistant to the manager and a newly appointed clinical manager/RN who was orientating on the day of audit, under the supervision of the operation's clinical manager. The clinical manager has 15 years within a DHB in the rehabilitation sector and as a clinical nurse specialist for gerontology. A section 31 was sent to HealthCERT for change of manager. The previous clinical manager has transferred to open a new Ryman facility and was unavailable on the day of audit.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Bert Sutcliffe has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance are 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, demonstrated their involvement in quality and risk management activities.</p> <p>Resident and relative surveys are completed annually. Care centre resident survey results for 2019 had improved from 2018 survey results. There had been an increase in resident satisfaction around care, food (with introduction of project delicious) and activities (with review of engage programme and introduction of walking groups). The overall score was 4.44 compared to 4.17 for 2018. The relative survey for 2019 is in progress. 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 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 assistant to the manger completes non-clinical audits and the clinical manager completes clinical audits. 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. Quality improvement plans have been developed for areas identified for improvement including call bell response times, increase in challenging behaviours in dementia care and falls with injury. Action plans have been implemented and demonstrated ongoing improvements in these areas. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee who are representative of health and safety officer/village manager, two health and safety representatives, back care champion/dementia unit coordinator, lineal manager and maintenance manager. A health and safety representative (interviewed) has completed stage 1 of health and safety and registered for the stage 2 health and safety course. The service has a health and safety objective around staff wellbeing and reducing muscular injuries. There are regular manual handling sessions taken by the physiotherapist, a site back care champion, return to work consultation with an occupational therapist and a focus on identifying and reporting hazards. Ryman have initiated</p>
---	-----------	--

		<p>“step back” cards that are completed following every incident to analysis and identify the root cause. The noticeboard keeps staff informed on health and safety meetings. Head office sends out health and safety bulletins regularly and alerts for staff information and awareness.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contract a physiotherapist 20 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>
<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 on VCare for each incident/accident with immediate action noted, relative notification and any follow-up action required.</p> <p>A review of 15 incident/accident reports including witnessed and unwitnessed falls and skin tears for August 2019 were reviewed and identified that all were fully completed and included follow-up by a registered nurse. Neurological observations are completed for unwitnessed falls and where there is an obvious knock to the head. The unit coordinators and managers review adverse events as part of the weekly management meeting.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. There have been four Section 31 notifications for 2018 (medication error, resident wandering, resident absconding and two stage three pressure injuries). There have been four Section 31 notifications for 2019 to date including two unstageable pressure injuries (March and September), change of manager (October 2018) and new manager (16 September 2019). The Public Health was notified of two outbreaks (February 2019 and July 2018).</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</p>	FA	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one assistant to the manager, one hospital unit coordinator, two registered nurses, three caregivers, one diversional therapist 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 was completed and annually thereafter. The assistant to the manager maintains staff files, records of annual practicing certificates for RNs, enrolled nurses and other health practitioners and records of staff education.</p> <p>A general orientation programme for all new staff is completed on site at an induction day. There was a group of new staff (including the newly appointed clinical manager) attending an induction day on the day of audit. The day 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</p>

<p>legislation.</p>		<p>programme is tailored specifically to the job role and responsibilities. Caregivers interviewed could describe the orientation process and felt staff were adequately orientated to their role.</p> <p>There is an implemented annual education plan that covers the mandatory training requirements and many topical debriefs/toolbox sessions at handovers. Repeated sessions for education/in-service and access to education notes/contents on the electronic system evidences good staff attendance. External speakers have included hospice, DHB medical specialists, Dementia Auckland and gerontology nurse specialist. Comprehension questionnaires and competencies (relevant to the roles) are completed annually. The bi-monthly RN meetings include the Journal club. There are 19 RNs and one enrolled nurse (serviced apartment coordinator). Six RNs are interRAI trained.</p> <p>There are 18 caregivers employed in the dementia care units and eight have completed their dementia unit standards with 10 (employed less than one year) are progressing through the standards.</p> <p>Ryman has a Careerforce assessor based at head office and the RNs have completed observer assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, assistant to the manager and clinical manager/RN work Monday – Friday. The unit coordinators for rest home and dementia care work Tuesday to Saturday and the hospital unit coordinator and serviced apartment coordinator from Sunday to Thursday. The RN in the hospital provides support to the rest home and serviced apartments as required.</p> <p>Rest home unit of 41 dual purpose beds (with 39 rest home residents on the day of audit) has on morning shifts; a unit coordinator or RN seven days, three caregivers on the full shift and one caregiver 0730 to 1300. On afternoons there are two caregivers on full shift and one caregiver until 2030. There are two caregivers on night shift.</p> <p>Serviced apartments with nine rest home residents on the day of audit: There is a senior caregiver who covers the serviced apartment coordinator days off. There are two caregivers on the morning (one finishes at 1330) and two caregivers on the afternoon shift (one finishes at 2100). The night shift is covered by caregivers/RN in the hospital.</p> <p>Dementia care unit of two 19-bed units (with 17 residents in each unit on the day): A RN covers the unit coordinator days off. There is an additional RN seven days a week on morning and afternoon shift that oversees both units. There are four caregivers on the morning shift in each unit (two finish at 1330). There are four caregivers on the full afternoon shift and two caregivers finish at 2100. They are supported by a lounge carer from 0800 to 1600 and the activities coordinator is on duty from 0930 to 1800 and they alternate their time between the two units. In the afternoon there is a lounge carer from 1600 to 2000 who works between the two units as required. There are three caregivers on the night shift.</p> <p>Hospital unit of 41 beds (with 40 hospital level residents on the day of audit): In addition to the unit coordinator there are two RNs on morning and afternoon shifts and one RN on night shift. There are four caregivers on the full</p>

		<p>morning shift and four caregivers on short shifts finishing at 1330. They are supported by a fluid's assistant from 0930 to 1300. There are two caregivers on the full afternoon shift and four caregivers on the short afternoon shift finishing at 2100. They are supported by a lounge carer from 1600 to 2000. There are three caregivers on night shift.</p> <p>Each unit has designated activities coordinator(s) and housekeeping staff. The physiotherapy assistant is based in the hospital unit.</p> <p>Residents and family members interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There are four medication rooms on site, one for each level of care and all have secured keypad access. Medications fridges had weekly temperature checks recorded and were within normal ranges. Registered nurses, enrolled nurses and senior caregivers, who have passed their medication competency, administer medications. Medication competencies are updated annually and include syringe drivers, subcutaneous fluids, blood sugars and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The service does not use standing orders.</p> <p>The facility utilises an electronic medication management system. Fourteen medication profiles were sampled (six hospital, four rest home and four dementia level of care). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of 'as required' medication administered was documented in the electronic prescription.</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>	FA	<p>The service has a well-equipped commercial kitchen on site where all food and baking is prepared and cooked. The qualified head chef is supported by a second chef and four kitchenhands. Staff have been trained in food safety and chemical safety. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Project "delicious" has been in place since opening. Menu choices are decided by residents (or family/EPOA/primary care staff if the resident is not able) and offer a choice of three main dishes for the midday and two choices for evening meal including a vegetarian option. Diabetic desserts and gluten free diets are accommodated. All meals are plated in the kitchen and delivered in hot boxes to each unit's satellite kitchen. The cook receives a dietary profile for all new resident admissions and is notified of any dietary changes. Resident likes and dislikes are accommodated and listed on the daily spreadsheet. Alternative foods are available on the menu or offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours a day. There is a supply of snacks in the dementia unit kitchenette.</p>

		<p>Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained for the cook and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing. The food control plan expires on the 11 January 2020.</p> <p>Residents can provide feedback on the meals through resident meetings, food communication books in each servery, resident survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a nursing review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Residents interviewed reported their needs were being met. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. There were 33 wounds on the day of the audit; 16 in the hospital (six pressure injuries, two skin tears and five vascular wounds and three ulcers), eight wounds documented in the dementia unit (three pressure injuries, four skin tears and one ulcer/skin graft), five in the rest home (three pressure injuries and two skin tears) and four wounds in the serviced apartments (one pressure injury and three skin tears). There was evidence of the wound care nurse specialist, GP, dietitian and facility wound champion involvement in the management of complex wounds and pressure injuries. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for all 33 wounds. There is a quality improvement plan in place for the prevention and management of pressure injuries. There have been three in-services on skin care, wound care and pressure injury prevention for 2019 to date. There were adequate pressure prevention resources available.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences.</p> <p>There is a suite of monitoring forms available on the myRyman system which include weight, vital signs, behaviour monitoring and assessment, pain, neurological observations and blood glucose monitoring. Progress notes documented changes in health status and significant events.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The team of activities staff (one diversional therapist and three activity coordinators) coordinate and implement the Engage activities programme, across the hospital, rest home, dementia units and serviced apartments seven days a week. Activities staff attend on site and organisational in-services relevant to their roles. All four activities staff hold current first aid certificates.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, themes events and celebrations, indoor bowls, sensory activities, baking in the kitchenettes, outings and drives. The service has a mobility van for resident outings. Rest home residents in the serviced apartments can attend the serviced apartment programme or rest home programme. One-on-one time is spent with residents who are unable to participate or choose not to be involved in the activity programme. Village friends visit and participate in some activities. Every Wednesday the residents enjoy a movie in the on-site movie theatre. Community involvement includes entertainers, speakers and church services. The activities staff have been successful in engaging residents in the Engage programme especially around the pampering sessions and men's club as evidenced in the residents' survey results.</p> <p>Both the wings of the dementia care unit have access to an outdoor garden setting, a 'sensory room' (including lava lamps, music, CDs, aromatherapy, pampering, massage and hand massage) and a 'quiet room' with butterfly themed décor, dimmed lighting and suitably arranged furniture. RNs interviewed stated these two rooms are often used to calm residents when agitated. Families also enjoy spending one-on-one time with their loved one in both these rooms. Residents in the dementia care unit are taken for daily walks (observed) around the indoor gardens.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans for the seven long-term residents were evaluated by the RN within three weeks of admission. Written evaluations identified if the resident/relative desired goals had been met or unmet. All changes in health status were documented and followed up. The multidisciplinary review involves the RN, activities staff resident/family and unit coordinator. The seven resident files reviewed reflected evidence of family being involved in the planning of care and reviews and if unable to attend, they receive a copy of the reviewed plans. In all the files reviewed the care plans had been read and signed by the resident/EPOA/family. There is at least a three-monthly review by the medical practitioner with the majority of the hospital level residents being seen monthly. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2:</p>	<p>FA</p>	<p>The building has a current warrant of fitness that is posted in a visible location (expires 11 October 2020). A 52-</p>

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>week preventative and reactive maintenance programme is in place.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register identifying any trends/analysis and corrective actions. Currently the newly appointed clinical manager will be the infection control officer and is being mentored by the Ryman infection control nurse specialist (new role since June 2019). Monthly reports are discussed at the management and full facility meetings. A six-monthly analysis of infections is completed and monitors infection rates against key performance indicators.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There have been two gastroenteritis outbreaks in February 2019 (suspected and not confirmed norovirus) and one in July 2018. The public health was notified for both outbreaks and daily case logs were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 service has been restraint free (with the exception of an emergency restraint) for the past three years. The restraint officer (currently the hospital unit coordinator) provides staff training around restraint minimisation and de-escalation of challenging behaviours.</p>

## Specific results for criterion where corrective actions are required

---

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

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

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

No data to display
--------------------

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

---

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

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

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

No data to display
--------------------

End of the report.