

# Charles Upham Retirement Village Limited - Charles Upham 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:

<b>Legal entity:</b>	Charles Upham Retirement Village Limited
<b>Premises audited:</b>	Charles Upham 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: 1 September 2020      End date: 2 September 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	116



# 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

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

Charles Upham is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital, and dementia level care for up to 122 residents. On the days of the audit there were 116 residents receiving care in the care centre including 3 residents at rest home level in the serviced apartments. The village manager (non-clinical) had been in the role for fifteen months and is supported by an assistant to the manager, and a clinical manager (registered nurse). The management team are supported by a regional manager and support staff at head office. The resident and relatives interviewed spoke positively about the care and support provided.

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

This audit identified that the service has fully met all standards.

Continuous improvements were identified around data analysis, reduction of weight loss, advance care planning and restraint minimisation.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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The service complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and appropriate to the needs of the residents. A village manager, assistant to the manager, and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided 24 hours a day, seven days a week. The resident 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.
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There is an information/welcome pack that includes information on each level of care. Registered nurses are responsible for initial assessments, risk assessments, interRAI assessments and development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, are individualised and evaluated six-monthly. The general practitioner or the nurse practitioner reviews residents on admission and at least three-monthly.

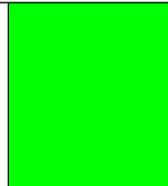
The activity team implement the Engage activity programme in the rest home/hospital and dementia units that ensures the abilities and recreational needs of the residents is varied, interesting and involves entertainers, outings and community visitors.

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

Meals are prepared on site. The project delicious menu is designed by a dietitian at organisational level and provides meal options including gluten free and vegetarian. Individual and special dietary needs are catered for. There are nutritious snacks available 24 hours in the dementia unit.

## 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.

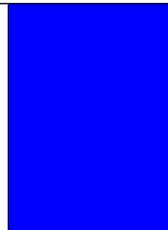


Standards applicable to this service fully attained.

The building has a current building warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensembles. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management. There is always a first aider on site. The environment is warm and comfortable. Housekeeping staff maintain a clean and tidy environment. All linen and personal clothing is laundered on site.

## 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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service currently had no residents requiring the use of restraint or enablers. The restraint coordinator maintains a register.

## 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 prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. The service has had two outbreaks in 2019. Covid-19 lockdown was well managed, and precautions remain in place as per current guidelines.

## 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>	2	44	0	0	0	0	0
<b>Criteria</b>	4	90	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code.</p> <p>Discussions with the village manager, assistant to the manager, clinical manager/RN, regional manager, and 29 clinical staff (14 caregivers who work across the facility, seven registered nurses (RNs), four unit coordinators, one recreation officer and three diversional therapist) confirmed their familiarity with the Code. Non-clinical staff including one laundry staff, one lead chef, one housekeeper and a maintenance person were also familiar with the Code. The Code is discussed at resident and staff meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. General consents including the consent for teleconference with medical and allied health professionals were sighted in the 11 files reviewed (four hospital level, four rest home including one resident in the serviced apartments and one resident under individual funding and three dementia care files). Specific consents were viewed for wound photographs and influenza vaccines. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Training was provided on informed consent in February 2019.</p> <p>Resuscitation status were signed by the competent resident and witnessed by the general practitioner (GP). Where the resident is unable to make a decision, the GP makes a medically indicated not for</p>

		<p>resuscitation in consultation with the enduring power of attorney (EPOA). The EPOA for the three-dementia level of care residents had been activated. Copies of EPOA and activation status are available on the residents' files. An education session is held around resuscitation, advance care planning, and advance care directives, held in May 2019 and 2020.</p> <p>Advance directives had been completed by the competent resident and medical care guidance had been completed by the EPOA in 94% of resident files. The service has been awarded a continuous improvement rating in recognition of its commitment to ensuring advance care plans were in place for residents.</p> <p>Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Admission agreements for 10 long-term resident files under the Aged Residential Related Contract (ARCC) had been signed within a timely manner. There was a written agreement for the resident under individual funding.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks. The caregivers and registered nurses interviewed could describe instances where an advocate would be required, and were aware of where this information is held.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting as current Covid-19 regulations allow. Visitors were observed coming and going during the audit. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, such as shopping. A range of entertainers, schools and kindergartens visit the facility as Covid-19 regulations allow, there are regular van outings to places of interest. There is an on-site hairdresser available. 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 involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p>	FA	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with the</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>resident and relatives demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Eleven complaints (five verbal and six written) have been lodged in 2019-20 (year-to-date). Verbal and written complaints are documented. All complaints had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned. All complaints were documented as resolved. Complaints are linked to the quality and risk management system. The service has reviewed the complaints for trends, however there were no identifiable trends seen. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>An information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. There is the opportunity to discuss aspects of the Code during the admission process. Interviews with one resident (hospital level) and ten relatives (four rest home, two hospital, and four special care unit) confirmed that the services being provided are in line with the Code, and that information around the Code had been provided to them.</p> <p>Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager or the clinical manager discusses the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. Staff have undertaken annual training on abuse and neglect during June 2019 with very good attendance. Caregivers interviewed showed a good understanding of the different types of abuse and neglect and signs and symptoms residents may present.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	<p>FA</p>	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. 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</p>

<p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>planning and visiting is encouraged. Links are established with Te Rūnanga o Ngāi Tahu who are available for residents and as a support to the village for any Māori related advice. Tuahiwi Marae welcome staff of Charles Upham for an annual marae visit. On the day of the audit, there was one Māori resident who did not identify with their culture. Team meetings document cultural considerations including Māori language week in TeamRyman meetings. A recent quality initiative is to enhance and strengthen the image of the Māori culture, learning about the culture and language.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. The resident and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All residents at the facility were able to speak and understand English. Cultural awareness, and resident values training was last held in June 2020.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries in respect of gifts.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (e.g., wound care, mental health) and staff education and training.</p> <p>The service has worked to improve services for residents and has implemented a number of quality initiatives as a result of satisfaction surveys, and monthly analysis of quality data. Continuous improvements have been awarded for addressing unintentional weight loss in the special care unit (SCU),</p>

		the analysis of quality data, restraint minimisation and advance care planning.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Charles Upham retirement village provides care for up to 122 residents at hospital, rest home and dementia level care in the care centre and up to 30 residents at rest home level care in serviced apartments. On the day of audit there were 116 residents in total, including three rest home level of care residents in the serviced apartments. There are two double rooms who have married couples sharing these. One rest home level resident was on an individual funding (IF) contract. All other residents were on the age residential care contract (ARRC).</p> <p>All rooms in the rest home (level one) and the hospital (level two) are dual-purpose. There were 39 (of 40) residents on level one – 38 rest home level care and one hospital level care by choice. Hospital level care is provided, with RN entry in progress notes daily. The hospital RN attends to this resident when no RN available in the RH. Physio is involved for this resident. No equipment is required, and the room is large enough to provide adequate room for cares. There is a married couple sharing a room (both rest home level care)</p> <p>On level two (hospital) there were 40 (of 40) residents; 39 hospital and one rest home level resident (married couple one rest home and one hospital sharing a double room at their request). The double rooms have been verified during previous audits.</p> <p>The ground floor also has two secure 20-bed special care unit (dementia care), there were 36 residents on the day of the audit. At the time of the audit the two units, which adjoin and have connecting doors. The units are staffed and operated as two.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are translated at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific village objectives 2020 and progress towards objectives is updated as part of the TeamRyman schedule. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and</p>

		<p>dementia care.</p> <p>The village manager at Charles Upham is non-clinical and has been in the role for fifteen months. She is supported by a clinical manager/registered nurse (RN) who has been in the role since May 2018 and has experience in age care. The assistant to the manager (non-clinical) has been in her role for four years and supports both the village and clinical managers in their roles. There are experienced unit coordinators in each area (registered nurses in the rest home, hospital and dementia units and an enrolled nurse in the serviced apartments). The team are also supported by a regional manager who was present during the audit. Ryman provide ongoing training for managers and clinical managers. The village manager has not yet completed training due to Covid-19; however, this is planned for October 2020. The clinical manager has completed in excess of eight hours education in the last year including Ryman leadership training.</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>In the temporary absence of the facility manager, the clinical manager, supported by the assistant to the manager, would cover the manager position. The regional manager would be available for support if required.</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>Charles Upham 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>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 the health and disability standards. 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 facility manager and assistant to the manger completes or</p>

	<p>delegates staff to complete non-clinical audits and the clinical manager or registered nurses/unit coordinators complete clinical audits. The service develops a corrective action plan for any audit result below 90%. A quality improvement plan (QIP) 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 surveys and audit outcomes, which is utilised for service improvements. Quality improvement plans have been developed for areas identified for improvement including (but not limited to); improving communication between the maintenance, gardening team with the residents, health and safety audit findings, and low staff satisfaction survey results in the special care unit (SCU). Corrective action plans have been implemented and demonstrated ongoing improvements in these areas, which are signed off when completed and discussed at meetings demonstrating progress towards closing the corrective actions. The service has exceeded the standard around quality data analysis.</p> <p>Resident and relative surveys are completed annually. Care centre resident survey results for 2020 showed overall satisfaction, with an average score of 4.65 out of 5.0 (up 0.15) from 2019. The results were classified into rest home and hospital responses. The results identified there was a decrease in satisfaction in the hospital responses around activities, food services and housekeeping. QIPs remain ongoing with the corrective action plans updated regularly demonstrating ongoing progress. Corrective action plans include the chef visiting the hospital unit monthly to discuss concerns and menu options. Meetings were held with staff and the activities team and the residents. Activities are discussed at resident meetings and the residents are providing feedback and progress is ongoing and evaluated regularly. Communication has improved between the management, residents and housekeeping staff following meetings around sharing information.</p> <p>The relative survey was held in 2019 and showed overall satisfaction, with an average score of 4.28 out of 5.0, up 0.22 from 2018. The 2020 relative survey out for relatives had just been completed at the time of the audit and results are pending. All surveys completed are analysed and compared with the previous year's results. QIPs are developed for areas of lower satisfaction. The results and QIPs are discussed at all meetings.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee (the maintenance person, the head gardener, one member of housekeeping, one caregiver, and the administrator). A health and safety representative interviewed (administrator) has completed levels 1 and 2 and is booked for level 4 in October. Ryman have initiated 'step back' cards that are completed following every incident to analyse 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. The hazard register is reviewed, and new hazards are discussed at the monthly meetings. Current initiatives include promoting incident reporting and 'step back' cards are ongoing.</p>
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		<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. Caregivers interviewed could describe falls prevention strategies as documented in myRyman care plans. Falls statistics remain under the Ryman benchmark.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident, with immediate action noted and any follow-up action required. Neurological observations were completed for all unwitnessed falls and where there was the potential for a head injury. The incident reports reviewed document opportunities to minimise future risks.</p> <p>A review of fifteen electronic incident/accident forms for the facility identified that all were fully completed and include timely follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings, providing an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify significant events that would be reported to statutory authorities, this has included notification of the outbreaks in 2019. Reports are sent to head office, who also advise on notifications.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation, and staff training and development. Fourteen staff files reviewed; (one clinical manager, two unit coordinators, two registered nurses, four caregivers, two diversional therapists, one lead chef, one assistant to the cook, and one housekeeper) included a signed contract, job description, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals.</p> <p>A register of registered nurses' practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice.</p> <p>There is an implemented annual education plan. Each month the service is informed, via TeamRyman regarding what education is to be provided as well as any resources needed. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Seventeen registered nurses and one enrolled</p>

		<p>nurse have completed their interRAI training. Registered nurses participate in two monthly RN/EN journal club which provides clinical updates and guidance. Coordinators are supported to attend the Ryman leadership training. All staff have completed the core competencies relevant to their role, with 142 staff completing the handwashing competency in 2020.</p> <p>There are 33 staff who work in the dementia unit, 26 have completed the dementia unit standards, and seven are in the process of completing the standards.</p> <p>There are 18 caregivers with level 4 NZQA, three with level 3 and two with level 2 NZQA 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>	<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.</p> <p>The service staffing includes:</p> <p>A village manager who works Monday to Friday, the assistant to the manager who works Monday to Friday and a clinical manager who works Tuesday to Saturday. The clinical manager, assistant to the manager and village manager are in addition to the rostered staffing.</p> <p>There is a unit coordinator for each unit and are included as part of the rosters.</p> <p>Staffing in the special care unit (36 residents) on the day of audit include the designated unit coordinator (registered nurse) from Sunday to Thursday, and a registered nurse Friday and Saturday from 7.30am to 4pm.</p> <p>Special Care unit one (18 residents) morning shift: 1x 7am to 3.30pm and 1x 7am to 1.30 pm and a lounge assistant from 9am to 4pm (shared across the two units).</p> <p>Afternoon shift: 1x 3pm to 11pm and 1x 3pm to 9pm, and a lounge assistant from 4pm – 8pm (shared across the two units).</p> <p>Night shift: one senior caregiver who is medication competent 10.45 pm to 7.15 am (shared across the two units), and 1x 11pm to 7am.</p> <p>Special Care unit two (18 residents): Morning shift: 1x 7am - 3.30pm and 1x 7am - 1.30pm and a lounge assistant from 9am to 4pm (shared across the two units).</p> <p>Afternoon shift: 1x 3pm - 11pm, and 1x 3pm to 9pm, and a lounge assistant from 4pm to 8pm (shared across the two units).</p> <p>Night shift: one senior caregiver who is medication competent 10.45 pm to 7.15 am (across the two units), and 1x 11pm to 7am.</p>

		<p>Staffing in the rest home unit (39 residents including one hospital resident) on the day of the audit include: a unit coordinator seven days a week, and a registered nurse Monday to Friday from 7 am to 3.30 pm.</p> <p>They are supported by four caregivers: 1x 7 am to 3.30 pm, 1x 7 am to 3 pm, 1x 7 am to 1.30 pm and 1x 7 am to 1 pm.</p> <p>The afternoon shift has four caregivers; 2x (one of whom is a senior caregiver), 1x 4 pm to 9 pm and 1x 5 pm to 8.30 pm.</p> <p>The night shift has one senior caregiver 10.45 pm to 7.15 pm and one caregiver from 11 pm to 7 am.</p> <p>Staffing in the hospital unit (39 residents including one rest home level) on the day of the audit include: the unit coordinator Sunday to Thursday. Two registered nurses on morning and afternoon shift and one registered nurse on night shift.</p> <p>They are supported by eight caregivers and a fluid assistant: 4x 7 am to 3.30 pm, 2x 7 am to 1.30 pm, 2x 7 am to 1 pm and 1x fluid assistants from 7 am to 3 pm.</p> <p>The afternoon shift has seven caregivers and a lounge caregiver: 2x 3 pm to 11 pm, 3x 3 pm to 9 pm, 2x 4 pm to 9 pm, and one lounge caregiver from 4 pm to 8 pm.</p> <p>Night has three caregivers from 11 pm to 7 am.</p> <p>It was reported that all staff help each other across wings.</p> <p>On the days of audit, staff on duty were visible and 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. The resident and relatives interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident's individual record within 24 hours of entry. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files were protected from unauthorised access. Entries were dated and included relevant caregiver or registered nurse, including designation. The electronic system (myRyman) demonstrated service integration of resident records.</p>
<p>Standard 1.3.1: Entry To</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives</p>

<p>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>		<p>interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry including specific information on dementia level of care and the safe environment.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term care.</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>	<p>FA</p>	<p>The service has a policy that 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 including advance directives or medical care guidance documentation. Transfer notes and discharge information was available in the hard copy resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All medications are stored safely in each unit. Registered nurses and senior caregivers' complete annual medication competencies and education. Registered nurses complete syringe driver training. Medication reconciliation of monthly blister packs and 'as required' blister packs is checked by an RN with the signature on the back of the blister pack. Any errors are fed back to the pharmacy. Hospital level impress medications are checked regularly for stock level and expiry dates. Medication audits are completed. There were three hospital level residents and two rest home residents self-medicating with a self-medicating assessment in place that are reviewed three-monthly by the GP. The medication fridge temperatures are taken weekly in the dementia care unit and rest home unit. The fridge medication temperatures are taken daily in the hospital unit as part of a corrective action plan for temperatures above the acceptable limit. Medication room air temperatures are taken and recorded daily. All eye drops, creams and sprays were dated on opening.</p> <p>The service uses an electronic medication system. Twenty-two medication charts were reviewed (eight hospital, eight rest home and six dementia care). All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that regular medications were administered as prescribed. 'As required' medications had the indication for use documented. The effectiveness of 'as required' medications were recorded in the electronic medication system and in the progress notes.</p>
<p>Standard 1.3.13: Nutrition,</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on site. The kitchen is located in the service area on the</p>

<p>Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>ground floor. The qualified chef (interviewed) is supported by a cook assistant and morning and afternoon kitchenhands each day. All food services staff have completed induction, food safety training and chemical safety.</p> <p>Project "delicious" is a four weekly seasonal menu with three menu choices for the midday meal and two choices for the evening meal, including a vegetarian option and gluten free foods. The seasonal menu has been designed in consultation with the dietitian at an organisational level. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident dislikes are accommodated, and alternative options provided. A weekly update on dietary requirements is received from the units. Pureed meals are provided. Lip plates are available to encourage resident's independence with meals. All meals are plated in the kitchen and delivered to the units in scan boxes. Special diets are name labelled. End-cooked temperatures and serving temperatures are taken and recorded. Each unit has a functioning satellite kitchen from where the breakfast is served. Nutritious snacks such as sandwiches, fruit, yoghurts are delivered to the dementia care unit and there was plenty of snacks, fluids and foods available in all the units.</p> <p>The food services are involved in catering for resident special events and functions and host the "chefs table" dining monthly. The service also operates the on-site café.</p> <p>The service has a food control plan that expires May 2021. Temperatures are taken and recorded for fridges, freezer, cooking and cooling and incoming goods. All foods were stored correctly, and date labelled. The chemicals are stored safely, and the chemical provider conducts checks on the dishwasher regularly. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings and direct contact with the food services staff. Resident and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>In the files reviewed, an initial assessment and relevant risk assessment tools had been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural, pain, wound and physiotherapy assessments were completed according to need. There are a number of assessments completed that assess resident needs holistically such as cultural and spiritual and activities assessments. The assessments generate interventions and narrative completed by the RNs that are transferred to the myRyman care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met. The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall, likes and dislikes. There were behaviour management plans in place for the three dementia care resident files reviewed. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident such as the GP, physiotherapist, geriatrician dietitian and palliative care nurse. This was integrated into the electronic myRyman individualised record.</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>The resident interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP or NP visit or nurse specialist consultant. The care plans are updated with any changes to care and required health monitoring interventions for individual residents are scheduled on the RN or caregiver work log.</p> <p>Wound assessments, treatment and evaluations were in place for 10 wounds (six rest home, two hospital and two dementia care). There were chronic leg ulcers, surgical wound, skin tears and lesions. There were no pressure injuries on the day of audit. All wounds are linked to the care plans. Photos were taken where relevant. There are two RN wound champions who receive ongoing wound care education. They review all wounds weekly. Referrals are made as necessary to the dietitian and wound nurse specialist. The service has adequate pressure relieving resources available.</p>

		<p>Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring requirements are scheduled on the work log and used to monitor a resident's progress against clinical/care interventions for identified concerns or problems. Monitoring forms reviewed on the electronic work logs included blood pressure, weights, blood sugar levels, pain, behaviour, repositioning charts, bowel records, food and fluids, intentional rounding and neurological observations. Intentional rounding is determined by the residents need including toileting, whereabouts of residents or falls risk.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an activity team of three diversional therapists and lifestyle coordinators to implement the Engage programme across all levels of care in the serviced apartments, rest home, hospital and dementia care unit. The programme is from Monday to Friday 9.30 am to 4.30 pm in the serviced apartments and rest home. Rest home residents in the serviced apartments can choose to attend the serviced apartments or rest home activities. The programme for the hospital and dementia care unit is from Monday to Sunday. The hours for the programme in the dementia care unit is from 9.30 am to 6 pm. Lounge careers are involved in activities. There are plenty of resources available.</p> <p>The Engage programme has been implemented. There are set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including but not limited to; Triple A exercises, board games, news and views, make and create, memory lane, gardening, walks, men's club, knitting circle, happy hour and sensory activities including pet therapy, baking and one-on-one pampering. Themed events and festive occasions are celebrated. Community links include pre-school and college children, church groups, pet therapy, yoga instructors, bridge club speakers and entertainers. There are weekly van outings/scenic drives for all residents. The van driver has a current first aid certificate. The activity programme has been disrupted during the Covid-19 lockdown period.</p> <p>Resident life experiences and an activity assessment is completed for residents on admission. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. The activity plan is incorporated into the myRyman care plan and evaluated six-monthly with the MDT review. Residents/relatives can feedback on the programme through the resident and relative meetings and surveys. The February 2020 survey results showed an improvement in resident/relative satisfaction with activities.</p>
<p><b>Standard 1.3.8: Evaluation Consumers' service delivery</b></p>	FA	<p>Six files of residents who had been at the service six months identified that long-term care plans had been evaluated by registered nurses. Five of eleven resident files were not due for a six-monthly evaluation (two hospital, two rest home and one dementia care). All initial care plans had been evaluated at three</p>

<p>plans are evaluated in a comprehensive and timely manner.</p>		<p>weeks prior to the development of the long-term care plan. Care plans had been updated with any changes to health and care. The serviced apartment coordinator/enrolled nurse completes interRAI assessments and care plans which are countersigned by the RN.</p> <p>Written evaluations describe the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. The multidisciplinary (MDT) review includes the RN, caregivers, DT, GP, physiotherapist, resident, relative and any other health professionals involved in the resident's care. A record of the MDT review is kept in the resident's hard copy file. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services was evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care from dementia care to hospital level, respite care to rest home and from rest home to dementia care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Relevant staff have completed chemical safety training. Gloves, aprons, and goggles were available for all care staff and laundry/housekeeping staff and available in sluice rooms and laundry/housekeeping areas. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing while carrying out their duties. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets and product information is available. The chemical provider monitors the effectiveness of chemicals and provides chemical safety training. There is a chemical spills kit available.</p>
<p>Standard 1.4.2: Facility</p>	<p>FA</p>	<p>The building has a current warrant of fitness that expires 30 January 2021. The care centre is across three</p>

<p><b>Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>levels: hospital care on level 3, rest home care on level 2 and dementia level of care on the ground floor. The 30 serviced apartments are across the three levels.</p> <p>The maintenance team (one full-time and one part-time person) address daily repair and maintenance requests (as sighted on the maintenance log) and monthly planned maintenance as scheduled. The part-time maintenance person (interviewed) has completed chemical safety training, first aid, manual handling, and site safety course. There is separate gardening and grounds team.</p> <p>The planned maintenance schedule includes the calibration of medical equipment, functional testing of electrical equipment and hot water temperatures in resident areas. Hot water temperatures in resident areas are stable below 45 degrees Celsius. Electrical registers are maintained for all residents.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space in the rest home and hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.</p> <p>Residents are able to access outdoor areas safely or with supervision. The rest home and hospital units have outdoor balconies with seating and shade.</p> <p>There is secure entry/exit to the two dementia 20 bed units on the ground floor. Each unit has access to two courtyard areas with walking pathways, raised gardens, seating and shade. One large courtyard can be accessed by residents from both units.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. The hospital unit has a large storage area for the three full hoists, two standing hoists and three sara steady's. There is a full hoist available in the rest home and dementia unit for use in case of falls.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>	<p>FA</p>	<p>All resident rooms (including the serviced apartments) have full toilet/shower ensuites. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Non-slip flooring and handrails are in place. Care staff interviewed confirmed they maintain the resident's privacy when undertaking personal 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 setting.</p>	<p>FA</p>	<p>There are two double rooms, one in the hospital unit and one in the rest home unit. All other resident rooms are single. All bedrooms and ensuites are spacious for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The hospital and rest home units have a large open-plan dining area with kitchenette and open plan lounge area. Seating is arranged to allow large group and small group activities to occur. Both units have a family room. All serviced apartments also have their own spacious lounge and kitchenette as well as communal dining areas. The village centre is on the ground floor with communal areas available to care centre residents including the café, movie room, reflection room and hair salon.</p> <p>Each dementia unit has an open-plan living area. Each living area is spacious with a separate dining area and a smaller lounge where residents can also dine. The spacious open plan area allows for quiet areas and group activities. The hallways and communal areas allow maximum freedom of movement while promoting the safety of residents who are likely to wander. There is free access to the safe outdoor gardens and walking pathways. There is a secure connecting door between the units that can be opened up for entertainment and larger group activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The laundry is located in the service area on the ground floor. The laundry has a double door entry and exit with defined clean/dirty areas. All linen and personal clothing is laundered on site. There are three laundry staff who work staggered starting and finishing times between 8 am to 10 pm. There are large commercial washing machines, sluice machine and dryers. The clean side has a large table for folding washing and a labelling machine. There is a large linen storeroom opposite the laundry.</p> <p>The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Material safety datasheets are readily accessible.</p> <p>Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Cleaner's trolleys (sighted) were well equipped. Trolleys are stored in locked cleaners' cupboards when not in use. A chemical dispensing unit is used to refill chemical bottles. All chemical bottles have the correct manufacturer's labels. Cleaners trolleys are kept in locked cupboards when not in use.</p> <p>Feedback is received through resident meetings and results of internal audits. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and</p>

		housekeeping areas.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Orientation includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The facility has an approved fire evacuation plan and fire drills take place six-monthly. The last fire evacuation drill occurred on 11 and 12 August 2020. Smoke alarms, sprinkler system and exit signs are in place.</p> <p>Emergency lighting is in place, which runs for at least two hours. The facility has an on-site diesel generator to run essential services. There is a civil defence kit located on each level. Supplies of stored drinkable water is stored in large holding tanks. There is sufficient water stored to ensure three litres per day for three days per resident (270,100 litres). There are alternative cooking facilities available with three gas barbeques and gas hobs in the kitchen. Gas heaters are available if required.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advised that they conduct security checks inside at night, in addition to an external contractor who checks the external area. A security camera is installed at the entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is ceiling heating throughout the facility. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. There is an infection prevention and control responsibility policy that included a chain of responsibility and an infection prevention and control coordinator's job description. The clinical manager is responsible for infection prevention and control at the facility and has previous experience in infection control coordination.</p> <p>The infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and</p>

<p>appropriate to the size and scope of the service.</p>		<p>directed via the TeamRyman calendar. The facility had developed links with the GPs, local laboratory, the infection control, and public health departments at the local DHB. Notices are displayed on entry to the facility reminding visitors not to visit if they are unwell.</p> <p>Due to current Covid-19 guidelines, all visitors and contractors must complete a wellness declaration and sign into the facility. All visitors and contractors are provided with a mask on entry to the facility. There were adequate supplies of infection control equipment on each floor in the case of outbreaks. A good supply of hand gel, masks and aprons are available.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control updates. Ryman is a member of Bug Control; the IC coordinator is a member of the New Zealand wound care society and the infection control society New Zealand. The infection control team is representative of the facility. Resident care plans reviewed included comprehensive documentation for any known infections.</p> <p>External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>The requirements during the Covid-19 lockdown and practices at all different levels have been adhered to. There are four large folders containing all information and processes for each level of lockdown. During the lockdown period, staff were provided with separate changing facilities at work on each floor, and for ancillary staff. All staff had very clear guidelines on infection control and laundering of uniforms. Residents adhered to the isolation and temperature checking. Activities were set up in hallways so residents could participate while adhering to social distancing. Education was provided for hand washing, and one on one training was provided for the correct techniques of donning and doffing personal protective equipment (PPE). The microbiologist provided training just prior to lockdown in March 2020. The facility continues to maintain current regulations by having a member of staff dedicated to greeting visitors at the entrance and ensuring they complete the electronic wellness declaration and sign in. Each visitor is provided with a mask, and visiting continues to be restricted to two visitors per person at any time, and visitors must see the resident in the resident's room.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention</p>	<p>FA</p>	<p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard, legislation, and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. Online training was provided around combatting Covid, PPE and handwashing was provided as required in March 2019. Infection control education separate to Covid was provided in April and September 2019.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator.  An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the monthly infection prevention and control (IPC) meetings. All meetings held include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation.  There have been two outbreaks at the facility since the last audit, both in 2019. One norovirus and one influenza were reported and managed well. Charles Upham have remained under benchmark for respiratory infection for a year.
Standard 2.1.1: Restraint minimisation Services demonstrate that the	FA	The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is a registered nurse with a job description that defines the role and responsibility of the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of

<p>use of restraint is actively minimised.</p>		<p>restraint and monitoring requirements. The approval group meet regularly when restraint is in use, all restraint and enablers are reported to TeamRyman monthly.</p> <p>The standard of restraint minimisation has been exceeded at Charles Upham.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>Restraints (when in use) are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator and members of the approval group. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme, and staff education and training and review.</p> <p>The standard has been exceeded around achieving restraint free.</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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	CI	<p>In May 2019, the service identified an area for improvement around communication and complying with residents' end of life cares.</p> <p>Advance directives had been completed by the competent resident and medical care</p>	<p>Charles Upham became the pilot village for implementation of advance care planning in association with the Amberley Medical Centre. The national Advance Care Plan document was used for the competent residents and the Medical Care Guidance (initially a Canterbury DHB document) has been utilised for the incompetent resident. This document is now rolled out nationally. Education was provided to the RNs by the Canterbury Initiative Advance Care Plan facilitator in July 2019. The importance of completing documents and progress was discussed at the weekly RN/EN meetings. An ACP champion role was created and supported to attend an ACP workshop in Christchurch, September 2019, where legal framework, ethical challenges, conversation with families and documentation. was discussed. The facility was recognised at the workshop for its success in rolling out the ACPs. Admitting RNs are required to have the advance care plan conversations and provide the ACP leaflets to the family and resident (as appropriate). There has been discussion around the importance of ACP at the six-monthly relative meetings. The ACP champion follows up the documentation, liaises with family, supports RNs and reviews the document prior to submission to the GP. The final document is loaded onto the Medical Centre Health 1 system where it is accessible to the DHB and St Johns ambulance service. The goal to have 80% ACPs for existing resident completed by December 2019 has been</p>

		<p>guidance had been completed by the EPOA or GP in 94% of resident files to date. The service has been awarded a continuous improvement rating in recognition of its commitment to ensuring advance care plans were in place for residents.</p>	<p>successful with 90% of ACPs completed. The aim now is to have the ACP or medical care guidance document completed within 21 days of admission. To date 94% of residents across the three levels of care have an advance directive in place. The GP confirmed that staff knowledge around end of life wishes reduces family concerns and there was excellent feedback from relatives interviewed on the high standard of care provided. The GP, regional manager and clinical manager stated there has been improved communication with residents and family members around end of life care and wishes, resulting in unnecessary acute hospitalisations and reduced after hours visits due to planned care interventions as required.</p>
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>CI</p>	<p>It was identified that twelve residents in the special care unit (dementia) were losing weight unintentionally. The aim was for no more than 10% of the residents were to be losing weight unintentionally. A quality improvement</p>	<p>Challenging behaviours were identified in the special care unit that were above average (3.68 compared to 3.0/1000 bed nights in the six months from June to December 2018). A QIP was developed in January 2019. Education was provided to staff around de-escalation, challenging behaviours, dementia, continence management and communication. There was a review of the resident behaviour care plans, and meetings were held with relatives. In the six months from July to December 2019 the clinical indicator remained low at 4.07 (benchmark 6.38/1000 bed nights) and the average from January to June 2020 is 3.67.</p> <p>Instances of bruising has decreased from 14.10/1000 bed nights to 3.23/1000 bed nights across the facility (below five across the facility per month since February 2020). Moisturising cream is prescribed, feedback of statistics and corrective actions are discussed at meetings, education around skin integrity, manual handling, hydration, and falls prevention have been provided.</p> <p>Fall statistics, urinary tract infections and facility acquired pressure injuries have remained below benchmark with staff education around falls prevention, physiotherapist input, food and fluid monitoring and intervention in care plans updated,</p>

		project (QIP) was developed around improving the dining experience.	and reminders at handovers. Monthly analysis and trending, incidents and infections monitor effectiveness of the strategies in place. The registered nurses and caregivers all fluently confirmed measures taken, corrective actions, discussion of statistics and ongoing progress as per minutes of meetings.
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The goal for Charles Upham was to reduce their quality data statistics to remain under benchmark within the Ryman organisation.</p>	<p>Challenging behaviours were identified in the special care unit that were above average (3.68 compared to 3.0/1000 bed nights in the six months from June to December 2018). A QIP was developed in January 2019. Education was provided to staff around de-escalation, challenging behaviours, dementia, continence management and communication. There was a review of the resident behaviour care plans, and meetings were held with relatives. In the six months from July to December 2019 the clinical indicator remained low at 4.07 (benchmark 6.38/1000 bed nights) and the average from January to June 2020 is 3.67.</p> <p>Instances of bruising has decreased from 14.10/1000 bed nights to 3.23/1000 bed nights across the facility (below five across the facility per month since February 2020). Moisturising cream is prescribed, feedback of statistics and corrective actions are discussed at meetings, education around skin integrity, manual handling, hydration, and falls prevention have been provided.</p> <p>Fall statistics, urinary tract infections and facility acquired pressure injuries have remained below benchmark with staff education around falls prevention, physiotherapist input, food and fluid monitoring and intervention in care plans updated, and reminders at handovers. Monthly analysis and trending, incidents and infections monitor effectiveness of the strategies in place. The registered nurses and caregivers all fluently confirmed measures taken, corrective actions, discussion of statistics and ongoing progress as per minutes of meetings.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use</p>	CI	<p>A quality initiative was developed in March 2019 to reduce the use of restraint and</p>	<p>The beds at Charles Upham are placed in the middle of the room, so residents can get out either side of the bed. Five residents were on restraint. A QIP was developed around reaching restraint free status. Education sessions were held around restraint minimisation, managing challenging behaviour and the residents code of rights. Intentional rounding was increased to 30 minutes, wider beds were purchased for residents at risk of rolling out of bed and were identified to be a high fall risk. Bed</p>

<p>and any trends;  (b) The organisation's progress in reducing restraint;  (c) Adverse outcomes;  (d) Service provider compliance with policies and procedures;  (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;  (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;  (g) Whether changes to policy, procedures, or guidelines are required; and  (h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>work towards becoming restraint free.</p>	<p>sensor mats are in place and floor sensor mats are in place at both sides of the bed for residents at high risk of falling.</p> <p>Physiotherapy was involved for residents at high fall risk to enable residents to move around independently, maintain muscle strength and maintain freedom and dignity. Caregivers interviewed described measures they take to prevent residents from falling, while respecting dignity and promoting independence including increased monitoring which is recorded in myRyman. Charles Upham has been restraint free since December 2019.</p>
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End of the report.