

# Grace Joel Retirement Village Limited - Grace Joel 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Grace Joel Retirement Village Limited

**Premises audited:** Grace Joel Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 7 October 2020 End date: 8 October 2020

**Proposed changes to current services (if any):** The service has reconfigured six serviced apartments that were certified for rest home level to be dual-purpose. Level one rooms 310 to 314 and level two room 411. The overall certified apartments remain at 30 which includes (24 rest home level and 10 dual-purpose). The service has also requested reconfiguration of eight large premium

rooms in the care centre as suitable as double rooms for married couples as needed. There are currently two married couples in two of these rooms. The following double rooms were verified as suitable for a couple– rooms 313, 314, 315, 316 on Hauraki (Level 1) and rooms 413, 414, 415, 416 on Waitemata (Level 2). This will increase bed numbers in the care centre from 99 beds to 107 beds. With overall certified beds at 137.

**Total beds occupied across all premises included in the audit on the first day of the audit: 99**

# 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
Yellow	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
Red	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

Grace Joel is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home and hospital level care for up to 137 residents. There were 99 residents at the time of the audit.

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

The village manager is appropriately qualified and experienced and is supported by a regional operations manager, an assistant to the manager, and a clinical manager/registered nurse. A unit coordinator is employed for each level of care (hospital, rest home, and serviced apartments). There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit identified that the service has met all the required standards.

The service has been awarded three continuous improvements around meals, laundry services and infection control.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

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

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, 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.

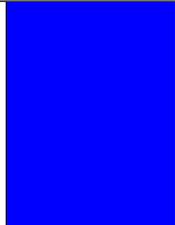
Quality and risk management programmes are being implemented. Corrective actions are established where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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. Education and training for staff includes in-service education and competency assessments.

Nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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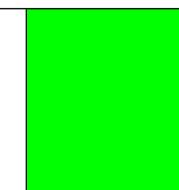
A comprehensive information/welcome pack is provided to all new residents and family on admission to services. Registered nurses are responsible for initial assessments, risk assessments, interRAI assessments, and development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, are individualised and evaluated six-monthly. The general practitioner reviews residents on admission and at least three-monthly.

The activity team implement the Engage activity programme in the rest home/hospital wings that ensures the abilities and recreational needs of the residents is varied and 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. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensuites. 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 a first aider on site at all times. The environment is warm and comfortable. Housekeeping staff maintain a clean and tidy environment. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had one resident with a restraint and one with an enabler. Appropriate processes are in place for the restraint and the enabler. Staff receive ongoing education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating/providing education and training for staff. The infection control coordinator has completed training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. Information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control. There have been no outbreaks.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	3	98	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 of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as part of their annual in-service programme. Interviews with staff confirmed their understanding of the Code. Staff interviewed included: four healthcare assistants (HCAs), three registered nurses (RNs), two-unit coordinators (also RNs), one laundry person, one lead chef, and two maintenance staff. Management team interviews included the regional operations manager, the village manager, the assistant to the manager and the clinical manager. The management team could provide examples of how the Code applies to their job role and responsibilities. Two rest home and four hospital residents and three hospital relatives interviewed confirmed that staff uphold the rights of residents.</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. Specific consents were viewed for wound photographs and influenza vaccines. Eleven resident files reviewed (four rest home including one resident in a serviced apartment, one respite and one young person with a disability [YPD]) and seven hospital level of care residents including one in a serviced apartment and one long-term chronic care included written consents.</p> <p>Advance directives and/or resuscitation status are signed for separately by the competent resident.</p>

<p>informed choices and give informed consent.</p>		<p>Where the resident is unable to make a decision, the GP makes a medically-indicated not for resuscitation order in consultation with the enduring power of attorney (EPOA). Copies of EPOA and activation status are available on the resident's electronic myRyman file under the EPOA icon. Healthcare assistants (HCAs) and registered nurses (RNs) interviewed confirmed verbal consent is obtained when delivering cares. Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Admission agreements for the eleven long-term resident files reviewed had been signed within a timely manner.</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>	<p>FA</p>	<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 family confirmed the service provides opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</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>	<p>FA</p>	<p>Residents and families interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The use of contact tracing and PPE as needed was strictly observed. The activities programmes includes opportunities to attend events outside of the facility. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain actively involved in community and external groups. Families and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<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 and on noticeboards. Interviews with residents and family members confirmed their understanding of the complaints process. Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register is in place. The service logs all complaints, including verbal feedback and issues raised through meetings. As a result of this thorough collection there were 22 complaints on the complaint log. All complaints documented an investigation and follow-up with the complainant. Six complaints were related to families concerns during the lockdown. Quality improvement plans were</p>

		<p>documented for some complaints including meals and care.</p> <p>There was a coroner's case letter from May, with no issues or findings raised by the coroner during 2020 and one HDC complaint around falls with no recommendations from the HDC.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Aspects of the Code are discussed during the admission process with the resident service manager. Residents and relatives interviewed confirmed that information had been provided to them about the Code. Large print posters of the Code and advocacy information are visually displayed throughout the facility on noticeboards.</p> <p>Families and residents are informed of the scope of services and any liability for payment of items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms and closing doors while care was being provided. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered and that staff were respectful and kind. Interviews with caregivers described how choice is incorporated into resident care provision.</p> <p>Instructions provided to residents on entry regarding responsibilities of personal belongings is in their admission agreement.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has implemented a Māori health plan. The service maintains at least annual contact with the iwi. He Kamaka Waioara, Māori Health service from the DHB, is available as liaison for Māori residents and as support to village for any Māori related advice.</p> <p>Ruapotaka Marae Kaumatua Kuia, Taumata group were part of the service celebrations during 2019 and have been asked again for 2020.</p> <p>There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. At the time of the audit, no residents identified as Māori.</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>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau are invited to be involved. Individual beliefs and values are also discussed and incorporated into the resident's care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with residents and family confirmed that residents' values and beliefs are considered.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include the role and responsibilities of the position. The monthly full staff meetings include discussions on professional boundaries and concerns as they arise. Interviews with managers and staff, confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<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 policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data is collected for each service level. It is reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include (but are not limited to) resident incidents by type, resident infections by type, staff incidents or injuries by type. Feedback is provided to staff. Quality improvement plans (QIPs) are developed where results do not meet acceptable targets.</p> <p>The myRyman electronic resident information (eg, care plans, monitoring charts) have been implemented that allow for one-on-one time with residents and less paper-based documentation. Interventions (eg, weight management, falls management strategies, pain management, neurological observations, behaviour management) documented on myRyman are reviewed by a registered nurse. MyRyman care plans provide evidence to indicate when cares are being delivered.</p> <p>A general practitioner or nurse practitioner visits the facility four times a week with 24/7 on-call services. Physiotherapy services are provided five days a week for a total of 20 hours, as well as a physiotherapy assistant five days a week. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists.</p> <p>The health and safety programme has introduced a 'stop and think' employee campaign using 'step-back'</p>

		cards. Staff are involved in identifying risks and hazard controls.
<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>Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Care plans reviewed identified family involvement in the care plan and progress notes document when family had been consulted or informed. Staff are required to record family notification when entering an incident into the database. Eleven adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ryman Grace Joel is one of the Ryman group of villages. The facility is modern and spacious. They are certified to provide rest home and hospital levels of care for up to 99 residents in the care centre. In addition, there are 30 serviced apartments certified to provide rest home level care including ten certified as dual-purpose. There were 99 residents on the days of audit. This included; 65 residents at hospital level including: one funded through the long-term chronic conditions contract (LTS-CHC) and five in the serviced apartments. There were 34 residents at rest home level including one younger person disabled (YPD), five respite and four in serviced apartments.</p> <p>The service has five floors/levels, the top floor is serviced apartments only. The second floor has serviced apartments and 49 dual-purpose beds in the care centre, the first floor has 50 dual-purpose beds in the care centre and also has serviced apartments, the ground floor has administration and serviced apartments, and the lower ground floor/level has village services (kitchen and laundry) and serviced apartments.</p> <p>The service originally had 30 serviced apartments certified to provide rest home level care including four dual-purpose serviced apartments. HealthCERT letter (dated 8 October 2019) identified that the service has reconfigured a further six serviced apartments to be dual-purpose. Level one rooms 310 to 314 and level two room 411. Overall certified apartments will remain at 30 which includes (20 rest home level and 10 dual-purpose). The service has also requested reconfiguration of eight large premium rooms in the care centre as suitable as double rooms for married couples as needed. There are currently two married couples in two of these rooms. The following double rooms were verified as suitable for a couple– rooms 313, 314, 315, 316 on Hauraki (Level 1) and rooms 413, 414, 415, 416 on Waitemata (Level 2). This will increase bed numbers in the care centre from 99 beds to 107 beds. With overall certified beds at 137.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually, specific to Grace Joel.</p>

		<p>Each objective includes an action place and person(s) responsible. There are specific projects with action plans related to clinical, health &amp; safety, human resources and resident/relative feedback. Details of progress are reported quarterly.</p> <p>The village manager at Grace Joel has been VM for 3 years and has attended Ryman leadership and other programmes. He is supported by an assistant to the manager, a clinical manager, three RN unit coordinators and a regional operations manager. The clinical manager (CM) has been in the role for six years.</p> <p>The managers have maintained more than eight hours annually of professional development related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The assistant to the manager and clinical manager are responsible during the temporary absence of the village manager with additional support provided by the regional operations manager. The UCs are responsible for clinical operations during the temporary absence of the clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management system that is directed by head office (Ryman Christchurch) is established and implemented. Quality and risk performance is reported across the facility meetings (TeamRyman committee meetings) and also to the organisation's management team. Discussions with managers and staff, and the review of meeting minutes demonstrated the collective involvement of managers and staff in quality and risk management activities.</p> <p>Resident meetings are held monthly. The village manager attends the meetings, and minutes are maintained. Resident and relative surveys are scheduled to be completed annually.</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 meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and</p>

		<p>templates for reporting. Service-appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed, meeting sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Each month the service documents an analysis of quality outcomes across a range of issues (falls, distressed behaviour, bruises, pressure injuries, urinary tract infections, respiratory infection and wound infections). The results of this report are used to determine the following month's actions. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. The internal audit programme is followed as per the schedule. Five of twenty-six internal audit results reflected less than acceptable outcomes (clinical care, health and safety, medication, wound care and waste management). A quality improvement plan (QIP) and or focus group was initiated for each of these internal audits and followed up. Two QIPs had been resolved.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Meetings are held monthly. The health and safety officer was interviewed (a maintenance staff member). There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. Health and safety data is tabled at staff and management meetings. A review of the risk register, and the maintenance register indicated that there is resolution of issues identified. All new staff and contractors are inducted to health and safety processes. There is also annual in-service training and competency assessments.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls. Healthcare assistants and RNs interviewed were knowledgeable in regard to preventing falls and identifying those residents who were at risk.</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>	<p>FA</p>	<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 using VCare for each incident/accident with immediate action(s) and any follow-up action required evidenced.</p> <p>A review of eleven incident/accident reports (eg, witnessed and unwitnessed falls, challenging behaviours) included follow-up by a registered nurse. There were timely neurological observations if there was a suspected injury to the head.</p> <p>The managers and unit coordinators are involved in the adverse event process via regular management meetings and informal meetings during the week that provide an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations would be reported to statutory</p>

		authorities. Notifications included: one coroner's investigation and one HDC complaint.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. Thirteen staff files were randomly selected for review (four HCAs, one clinical manager, three-unit coordinators, one chef, two activities staff and two RNs). Each file included an application form and two reference checks, a signed employment contract, job description, police check, and completed orientation programme. All files reviewed also included an annual performance appraisal.</p> <p>A register of registered nurses and one enrolled nurse's current practising certificates are held on site. Practising certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. The general orientation programme that is attended by all staff, covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Healthcare assistants are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Healthcare assistants are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme. The service is active with the Careerforce programme for staff; 24 HCAs have achieved level three Careerforce, eleven level four and 27 the dementia unit standards.</p> <p>There is an implemented annual education plan and staff training records are maintained. Staff also complete annual competency questionnaires. RNs are supported to maintain their professional competency. Seventeen of nineteen RNs have completed their interRAI training. RNs and ENs attend journal club. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>There are implemented competencies for RNs and Healthcare assistants related to specialised procedures or treatments including (but not limited to) medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, assistant to</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>the manager and clinical manager work Monday – Friday.</p> <p>Three-unit coordinators; there is one for level two; Waitemata, there is one for level one; Hauraki and one for the serviced apartments levels three and ground floor. Unit coordinators work Monday to Friday.</p> <p>The levels one and two care floors are all dual service beds (hospital and rest home). The hospital level serviced apartment beds are located very closely to the nurse’s stations on each of the two floors. Up to 30 serviced apartments can provide rest home level care including 10 located next to the care centre that can provide dual-purpose level care.</p> <p>Staffing for level two Waitemata unit. There are 54 beds on this floor of the care centre (including four double rooms). There were 32 residents at hospital level and 13 rest home level.</p> <p>The floor is staffed with two RNs on the AM shift and two across the PM shift and one for the night shift.</p> <p>Five long and four short HCAs are on the AM shift, three long and three short HCAs are on the PM shift and three HCAs on the night shift.</p> <p>Staffing for level one Hauraki unit. There are 53 beds on this floor of the care centre (including four double rooms). There were 28 residents at hospital level and 18 rest home level. The floor is staffed with one RN on the AM shift and one for each for the PM and the night shift. Three long and three short caregivers are on the AM shift, three long and three short caregivers are on the PM shift and two caregivers on the night shift</p> <p>In the serviced apartments, there are currently nine residents (five hospital and three rest home). There is a unit coordinator on the morning shift Tuesday to Saturday and a senior care assistant on Sunday and Monday. There are three care assistants (one full and two short-shifts) on morning shift and three care assistants (one full and two short-shifts) and three care assistants on afternoon shift. The hospital RN and care staff covers the serviced apartment on night shift.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident information (hard copy and electronic) is protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation.</p>

recorded, current, confidential, and accessible when required.		Residents' files demonstrated service integration.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-administering on the day of audit. A consent form had been signed and the resident deemed competent to self-administer. The eye drops, and creams were stored safely. There are no standing orders. There are no vaccines stored on site. There are three secure medication rooms across each floor.</p> <p>The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs have syringe driver training by the hospice. The medication room temperature is checked daily and the fridge temperature is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Twenty-two medication charts were reviewed (fourteen hospital and eight rest home). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
Standard 1.3.13: Nutrition, Safe	CI	The service has a lead chef and a cook who work full time. There are two kitchen assistants and one

<p><b>Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>kitchenhand. All cooks have current food safety certificates. The lead chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals and baking are cooked on site. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted.</p> <p>The food services are involved in catering for resident special events and functions and host fine dining every two weeks. On the day of audit, the lead chef gave a cooking demonstration in the serviced apartments.</p> <p>The food control plan was verified on 11 January 2020.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to myRyman care plan interventions. There was an initial assessment and plan for the respite resident. Other assessment tools in use included (but not limited to) nutrition, wound and continence.</p> <p>Assessments are also completed when there is a change in health status or incident and as part of completing the six-monthly care plan review. When assessments are due these are automatically scheduled in the RNs electronic daily calendar.</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 myRyman care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Changes to a resident's health status are altered in/added to the care plan. Residents and relatives interviewed stated that they were involved in the care planning process and there was documented evidence of this. There was also evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse, gerontologist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and there was documented evidence of this. All myRyman care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of the care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on electronic incident forms and written in the progress notes. Neurological observations are completed as per policy. Family are notified.</p> <p>Care staff interviewed stated that there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Electronic wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. RNs are notified on the daily electronic schedule when wounds are due to be redressed. There are currently sixteen wounds being treated. One chronic wound has had input from the GP and wound care nurse and there are photos of the wounds progress. There are currently four pressure injuries. One is non-facility acquired. The stage three pressure injury has had input from the GP, wound care nurse and dietitian and there are photos of the injuries progress. Pressure relieving equipment is available and is being used. HCAs document changes of position electronically.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs and wounds. Electronic behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>There is one diversional therapist who works 26 hours a week and two activities and lifestyle coordinators, one of whom works 32 hours a week and the other 25.5. This team covers Monday</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>through Sunday. There is one activities and lifestyle coordinator for each level, but they also work closely together and share many activities such as church services, happy hour and entertainment. There is also an activities and lifestyle coordinator in the village, and she works closely with the serviced apartment activities and lifestyle coordinator and they share many activities. On the day of audit residents were observed listening to news and views, participating in triple A exercises, going for walks, playing balloon tennis and enjoying an Oktoberfest celebration.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Each resident is also given a copy of the weekly programme to keep in their room. The Ryman Engage programme is utilised and residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. Each lounge has an activities box which may be utilised by all staff at any time. There is a monthly theme. There is a men's club and a knitting group. Aqua-aerobics is held in the pool weekly. This has just recommenced post level-three lockdown.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is an interdenominational church service weekly and a Catholic service every Sunday.</p> <p>Each area has a van outing twice weekly.</p> <p>Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. There is entertainment every week at Happy Hour. Every second Friday residents may choose to go to 'fine dining', but this is at their expense.</p> <p>There is pet therapy every second month. Some residents in the serviced apartments have their own cat.</p> <p>There is community input from the local preschools, schools and Māori cultural groups. A group of volunteers come in weekly to read to residents.</p> <p>Residents attend groups such as embroidery club, bridge club and the RSA. Some residents go out shopping or for coffees.</p> <p>The one YPD resident has a mild intellectual impairment and is happy to just join in the activities on offer.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. The activity assessment is incorporated into the myRyman care plan and evaluated at least six-monthly at the same time as the review of the long-term care plan.</p>
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		Resident meetings are held monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All plans reviewed (with the exception of the respite resident) had been evaluated by the registered nurse six monthly. Care plans had been updated with any changes to health and care. Activities plans (incorporated in the myRyman plan) had also been evaluated six-monthly. The multidisciplinary review involves the RN, GP, physiotherapist and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan and the results of the review if unable to attend.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people and the hospice. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for all care staff and laundry/housekeeping staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that	FA	The building holds a current warrant of fitness which expires 13 November 2020. There is a head maintenance person who works full time and is available on call. There are two part time assistants. There are two full time gardeners and one part time assistant. Contracted plumbers and electricians are available when required.  There is a reactive maintenance and planned maintenance schedule. Electrical equipment has been

<p>are fit for their purpose.</p>		<p>tested and tagged. The hoists and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range.</p> <p>The building is across three levels and there are lifts between each floor.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the rest home and hospital wings 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. Seating and shade are provided.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The service has reconfigured a further six serviced apartments that were certified for rest home level to be dual-purpose. Level one rooms 310 to 314 and level two room 411. Overall certified apartments remain the same at 30 which includes (20 rest home level and 10 dual-purpose). The dual-purpose rooms are close to the hospital and are spacious enough to manage equipment.</p> <p>The service has also requested reconfiguration of eight large premium rooms in the care centre as suitable as double rooms for married couples as needed. There are currently two married couples in two of these rooms. The following double rooms were verified as suitable for a couple– rooms 313, 314, 315, 316 on Hauraki (Level 1) and rooms 413, 414, 415, 416 on Waitemata (Level 2). This will increase bed numbers in the care centre from 99 beds to 107 beds. With overall certified beds at 139.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<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. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>All rooms are single. There are two married couples who share a room, and the rooms are sufficiently spacious to accommodate this. These rooms were verified at this audit as suitable for couples. Privacy screens are available if required. All bedrooms and ensuites are spacious for the safe use and</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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>	FA	<p>Each floor (unit) has a large open-plan dining area with kitchenette and lounge area. On one side is a spacious lounge and the other side is the dining area. There is another smaller quieter lounge/library located off the main lounge. The open plan lounge is large enough for individual or group activities. All serviced apartments also have their own spacious lounge and kitchenette. Rest home and hospital residents in serviced apartments can access the lounges in the care centre or the village lounge.</p> <p>The ground floor level is the village centre with communal areas available to care centre residents including the library, shop, chapel, gym, swimming pool and hairdressers.</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>	FA	<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 lower ground service area. The laundry has a double door and has an entry and exit with defined clean/dirty areas. All linen and personal clothing is laundered on site. There are two full time laundry staff seven days a week and one assistant from 3 pm – 6 pm. All laundry is sorted prior to washing. There are large commercial washing machines and dryers. There is a large folding table and laundry is placed into a delivery trolley for distribution to resident rooms. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Material safety datasheets are readily accessible. There has been some previous dissatisfaction with laundry services.</p> <p>Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Cleaners' trolleys were well equipped, and all chemical bottles had the correct manufacturer's labels. Cleaners' trolleys are kept in locked cupboards when not in use. There is a sluice room on each care centre level. Each sluice room has a sluice washing machine.</p> <p>Residents interviewed stated they are happy with the cleanliness of their bedrooms and communal areas. Other 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 housekeeping areas.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The care centre has an approved fire

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>evacuation plan and fire drills take place six monthly at a minimum. Smoke alarms, sprinkler system and exit signs are in place. The service has emergency generators on site that are serviced by an external contractor. There are gas BBQs available in the event of a power failure and torches. Emergency lighting is in place. There are civil defence kits in each unit and adequate stores of drinkable and non-drinkable water on site.</p> <p>The call bell system is available in each resident room. There are call bells and emergency bells in communal areas. There is a nurse presence bell when a nurse/carer is in the resident room; a green light shows staff outside that a colleague is in a particular room. The call bell system has a cascading system of call recognition that cascades if not responded to within a certain time from the primary nurse (caregiver) to the unit coordinator, to the clinical manager and to the village manager. The system software is monitored. Residents are also issued with call bell pendants for those who are able to use them. Security processes are in place.</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>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. There is gas heating throughout the facility. Staff and residents interviewed stated that this is effective. All areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. An infection control coordinator (unit coordinator) is responsible for infection control across the facility. A job description outlines the role and responsibilities. The infection prevention and control committee meet two monthly and comprise of a cross-section of staff. The infection control coordinator provides monthly reports to head office and to the full facility meetings.</p> <p>The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually by head office.</p> <p>All visitors and contractors are required to complete an electronic health declaration which also serves as contact tracing. Residents and staff are offered the annual influenza vaccine. All staff are now required to have an influenza vaccine prior to commencing work at Ryman as part of the Ryman initiative against Covid-19. Residents transferring from hospital or the community are placed in isolation for 14 days. There are adequate hand sanitisers and signage throughout the facility. There is an outbreak management bin and an ample stock of personal protective equipment that is checked weekly.</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>The infection control coordinator completed the infection control induction on appointment to the role and attends an annual head office organised education programme via teleconferencing.</p> <p>The facility has access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p> <p>Grace Joel have implemented the Ryman Covid-19 precautions. All visitors wear masks, have temperatures recorded and must complete health screening. An additional cleaning schedule has been implemented. Weekly updates from the central office have been sent to all Ryman facilities including Grace Joel.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. There is resource information and plans around Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions, and training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits six monthly. In-services have been provided around personal protective equipment and outbreak management and there has been particular emphasis on this since Covid-19. Infection control is an agenda item on the full facility and clinical meeting agenda. Any new communication regarding Covid-19 is relayed to staff via the myRyman noticeboard and at handovers.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in</p>

		ensuring this occurs.
<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>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the online resident files. Infections are included on an electronic register and the infection prevention coordinators complete a monthly report. Monthly data is reported to the infection control committee and meeting minutes are available to staff. Staff are informed of surveillance through the variety of clinical meetings held at the facility. The infection prevention and control programme links with the quality programme including internal audits. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking against other Ryman facilities occur. Quality improvements are commenced for any areas identified for improvement. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>An RN unit coordinator is the restraint coordinator. On interview she confirmed her knowledge around both restraints and enablers. During the audit, there was one resident using a restraint and one with an enabler.</p> <p>Staff training including staff competencies are implemented addressing restraint minimisation and enablers, falls prevention and analysis, and the management of challenging behaviours. This begins during their induction to the service and continues annually.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (unit coordinator/RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p> <p>The files of one resident with a restraint and one with an enabler both documented a robust consent and approval process.</p>

restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RNs in partnership with the GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two files were selected for review (both bed rails, one was a restraint, and one was an enabler). The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence was documented to verify checks were evidenced on the monitoring form for the two residents' files where restraint was in use.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted six-monthly. Restraint use is discussed in the RN meetings, confirmed in the meeting minutes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>

monitoring and quality review of their use of restraint.		
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## 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 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The four-weekly menu cycle is approved by a dietitian. The residents have a choice of two options for lunch and dinner. Residents can provide feedback on meals through feedback books (at each level), residents’ meetings and direct contact with the food service staff. All residents/families interviewed were satisfied with the meals.</p>	<p>In February 2018 the service identified that the meal service was an area for improvement and commenced a programme to improve the meal service.</p> <p>A variety of interventions were implemented including; two choices for the evening meal, the chef serving meals to residents on a rotating basis through each of the dining rooms, encouraging feedback on meals by providing comment books in the dining room and ensuring the feedback was communicated to the kitchen. There was also additional training for staff around food handling and food presentation. New menus were implemented for lunch and dinner.</p> <p>The plan documents regular evaluation and changes depending on the resident feedback and changes included raising the standard of food purchased, providing more savoury snacks and providing more seasonal vegetables with meals. Some meals were adapted for particular resident preferences such as adding honey to whipped cream and more gravy/sauce with meals.</p> <p>As a result of these interventions, resident surveys identified an improvement in meal satisfaction in the 2020 survey, from 3.61/5 for 2019 to 3.64/5 for 2020. The project has also impacted on the overall weight of the residents with a steady reduction in the total amount of</p>

			residents losing weight.
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	<p>Dissatisfaction with laundry services was evident in the care centre relatives' survey in February 2018. The facility commenced a project to improve laundry services, decrease the amount of unlabelled and lost clothing and increase support systems to support laundry personnel.</p>	<p>A quality project was implemented. The facility now has regular 'huddles' with the laundry personnel. A new labelled clothing request form has been developed and delicate clothing has distinctive red labels to avoid shrinkage. Laundry staff have had education around checking labels for each clothing item before washing so as to capture any clothing that may accidentally be unlabelled. Care centre staff have had education on the laundry process and what delicate clothing looks like. Laundry material charts are displayed in all sluice rooms. Laundry audits are conducted regularly to ensure the laundry is operating as per policy. Any clutter in the laundry is removed so there is always a clear area for labelling which reduces the risk of lost items. There is an ironing priority list to ensure those who expect fast turn-around have their expectations met. There has been a reduction in lost property evidenced since the implementation of the project. Laundry audits met with 94% compliance. In August 2020, the relatives' satisfaction survey was up to 4.30 from 4.06 in August 2019. In February 2020, the residents' satisfaction survey was up from 4.22 to 4.77 in February 2019.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a</p>	CI	<p>A review of the clinical indicator data showed that urinary tract infection (UTI) rates in the rest home were high with August 2019 at 3.47/1000 bed nights and at its highest, reaching 4.49/1000 bed nights in December 2019. The facility aimed to reduce rates in the rest home below the industry benchmark of 1.5/1000 bed nights.</p>	<p>A trend analysis of UTI rates was completed. The GP is involved as soon as an UTI is suspected.</p> <p>Fluid intake is encouraged –</p> <ul style="list-style-type: none"> <li>* a jug of water is always on hand for residents (unless on fluid restriction)</li> <li>* residents are taken to the lounge after cares so fluid intake can be monitored and encouraged</li> <li>* drinks of choice are offered</li> <li>* smoothies/high protein drinks are offered if resident has a poor appetite</li> <li>* a food and fluid chart is commenced if intake is inadequate.</li> </ul> <p>RNs review and clean suprapubic catheter sites daily. In-service training on prevention of UTIs, continence and catheters has occurred. There are scheduled toileting rounds for immobile residents and those residents with cognitive impairment are reminded to go to the toilet. UTIs are reviewed through monthly PowerBi reports. UTI numbers, trends and preventative interventions are discussed at all relevant meetings.</p>

timely manner.			Since implementation there has been a significant reduction in UTI rates. There was a spike in March 2020 at 2.73/1000 bed nights and July 2020 at 2.17/1000 bed nights but apart from that for five of the past nine months most of the UTI rates were minimal or zero.
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End of the report.