

Edmund Hillary Retirement Village Limited - Edmund Hillary Retirement Village

Introduction

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

The audit has been conducted by 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:	Edmund Hillary Retirement Village Limited
Premises audited:	Edmund Hillary Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 December 2020 End date: 9 December 2020
Proposed changes to current services (if any):	.
Total beds occupied across all premises included in the audit on the first day of the audit:	192



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
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

Edmund Hillary is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 236 residents. There were 192 residents at the time of the audit.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services 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 resident services manager and a clinical manager. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

The service continues to maintain continuous improvements around reducing falls, food services, and the restraint minimisation programme.

This audit identified one shortfall around medication management.

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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Discussions with residents and relatives confirm that residents and their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, facilities manager, clinical manager and resident services manager are responsible for 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 that is specific to their job role and responsibilities. On-going education and training for staff includes in-service education and competency assessments.

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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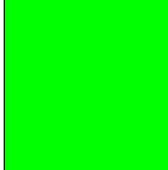
There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

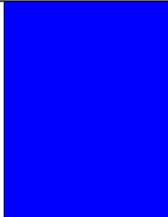
All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is posted in a visible location. There is a monthly maintenance plan that includes environmental, building and resident equipment checks.

Restraint minimisation and safe practice

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

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	14	0	0	1	0	0
Criteria	3	37	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with six residents (two hospital, four rest home) and family members confirmed their understanding of the complaints process. Staff interviewed (eight caregivers who work across all areas (rest home, hospital, dementia, serviced apartments) on both the AM and PM shifts, one head chef, two diversional therapists and five registered nurses) were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction.</p> <p>Nine complaints have been lodged in 2020 (year to date). One complaint was lodged with the DHB and has been closed following an investigation. One complaint has been lodged with HDC and remains open. A response to HDC has been submitted. Quality improvements linked to this complaint have been implemented including (but not limited to) a series of staff in-services (e.g., acute deterioration, recognising dying, gradual deterioration, communication, death and dying, recognising and defining frailty, syringe driver), and improving staff compliance (e.g., end of life care documentation). Two additional complaints were selected for review around resident care. These complaints were responded to in a timely manner and have been closed with actions taken to resolve any</p>

		<p>issues.</p> <p>The complaints process is linked to the quality and risk management systems. There is evidence of complaints received being discussed in staff and management meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to contact and record family notification when entering an incident into the database. Incidents reviewed met this requirement. Six family members interviewed (three hospital, three dementia) confirmed they are notified following an adverse event or a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters are available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Edmund Hillary is a Ryman healthcare retirement village. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. It provides rest home, hospital and dementia levels care for up to 236 residents. This includes 40 serviced apartments certified to be able to provide rest home level care. The units are broken down into the following. (i) Aoraki unit is a 43-bed dual-purpose unit; (ii) Olivier unit is a 42-bed hospital unit; (iii) Kathmandu unit is a 30-bed hospital unit; (iv) Himalaya unit is a 50-bed dual purpose unit; (v) Tibet special care units (two stand-alone units with a total of 30-beds).</p> <p>Occupancy during the audit was 192 (49 rest home level residents (which includes 6 in the serviced departments), 114 hospital level residents and 29 dementia level residents. There were two hospital level residents on respite and one hospital level resident on ACC. The remaining residents were on the age-related residential care services contract (ARRC).</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values and beliefs are documented that are specific to Ryman Edmund Hillary. Organisational objectives for 2020 are defined with evidence of monthly reviews and quarterly reporting to Ryman Christchurch on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2020 objectives.</p> <p>The village manager at Edmund Hillary has been in the role for over eight years. A facilities manager, resident services manager and clinical manager (registered nurse (RN)) provide management support to the village manager. The clinical manager is new to her role (July 2020). The management team is supported by a regional manager.</p>

		<p>The management team have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Edmund Hillary has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers (village manager, residential services manager, Ryman operations clinical manager, clinical manager) and staff and review of management and staff meeting minutes demonstrates their involvement in quality and risk management activities.</p> <p>Resident meetings are scheduled two-monthly for each wing and relative meetings are scheduled six-monthly. The village manager attends the meetings and minutes are maintained. Resident and relative surveys are completed annually. Results for the 2020 residents survey (sample of 50 responses) reflected improvements compared to 2019 with a ranking of 17 out of 32 care facilities. The 2020 relatives survey also reflected improvements compared to 2019 results with a rank of 10 out of 32 facilities. Quality improvement plans (QIPs) were identified where issues were noted (e.g., food satisfaction).</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, 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. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings. A health and safety officer (facilities manager) is appointed who has completed stage two health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. A review of the hazard register and the maintenance register indicates that there is resolution of issues identified. All contractors are inducted to health and safety processes by maintenance staff. All new staff are inducted and orientated to the facility and are advised of the health and safety programme. There is also annual in-service training.</p>

		Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Falls have continued to reflect a reduction for rest home level residents and have remained low (below the threshold) for the 2020 calendar year since August 2020. This previous rating of continuous improvement remains.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident reports are completed electronically on V-care for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of fifteen incident/accident reports (e.g., witnessed and unwitnessed falls, skin tears, bruising, pressure injuries) identified that all are fully completed and include follow-up by a registered nurse. Neurological observations are completed for unwitnessed falls or any suspected injury to the head. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations would be reported to statutory authorities. Examples were provided which included notification (Section 31 reporting) for pressure injuries (three stage three and two unstageable) and one complaint lodged with HDC.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. Nine staff employed since the previous audit were selected for the HR files review (eight caregivers, one dining assistant). All files included evidence of a signed contract, job description relevant to the role the staff member is in, police check, induction (general and specific), and reference checks. All files reviewed also included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of registered nurse and enrolled nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners (general practitioners and nurse practitioner, physiotherapist, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. A general orientation programme that is attended by all staff covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and</p>

		<p>complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme and achieve a level two NZQA (New Zealand Qualification Authority) qualification on completion.</p> <p>There is an implemented annual education plan and staff training records are maintained. Training is offered multiple times/days to ensure that staff are able to attend. Staff also complete competency questionnaires annually. Registered nurses are supported to maintain their professional competency. Thirteen of thirty-six registered nurses have completed their interRAI training. 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>All staff employed with Ryman Edmund Hillary are expected to complete dementia training with Ryman currently in the process of implementing an NZQA (New Zealand Qualification Authority) approved dementia course. In the dementia unit, twenty caregivers are employed to work in this unit, ten have completed their dementia qualification and ten are currently in the process of completing theirs. They have one year to complete this qualification in order to continue to work in the dementia unit as per Ryman policy.</p> <p>There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including (but not limited to) medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, facilities manager, resident services manager work Monday – Friday and clinical manager/RN works Sunday - Thursday.</p> <p>Aoraki wing (occupancy 37 hospital and 3 rest home level residents) is staffed with a unit coordinator/RN Tuesday – Saturday. Two staff RNs cover both the AM and PM shifts and one RN covers the night shift. The am shift is staffed with four long and four short shift caregivers, the PM shift is staffed with four long and four short shift caregivers and the night shift is staffed with two long shift caregivers. In addition, a fluid assistant is rostered 0930 – 1300 and a lounge carer is rostered 1600 – 2000.</p> <p>Olivier wing (occupancy 41 hospital level residents) is staffed with a unit coordinator/RN Tuesday – Saturday. Two RNs cover the AM and the PM shifts. One RN covers the night shift. The AM shift is staffed with five long and four short shift caregivers, the PM is staffed with three long and five short shift caregivers and the night shift is staffed with two caregivers. In addition, a fluid assistant is rostered on the AM shift and a lounge carer is rostered on the PM shift.</p> <p>Kathmandu wing (occupancy 26 hospital level residents) is staffed with a unit coordinator/RN Sunday – Thursdays. One RN covers the AM shift with a second RN staffed the two days the unit coordinator is not available. One RN is staffed on the PM shift and one RN is staffed on the night shift. The AM shift is staffed with three long and two short shift caregivers, the PM shift is staffed with two long and short shift caregivers and the night shift is staffed with two</p>

		<p>caregivers. In addition, a fluid assistant is rostered on the AM shift and a lounge carer is rostered on the PM shift.</p> <p>Tibet wing (occupancy 29 dementia level residents across two separate units) There is a unit coordinator/RN Tuesday – Saturday across both units. One staff RN covers the AM shift with a second RN rostered on the two days that a unit coordinator is not available. One RN covers the PM shift from 1600 – 2100). The AM shift is staffed with two long and one short shift caregivers, the PM shift is staffed with one long and one short shift caregiver and the night shift is staffed with three long caregivers, one who is a designated senior caregiver. In addition, a dining assistant is rostered from 1000 – 1400 and a servery assistant is rostered from 1400 – 1930.</p> <p>Himalaya wing (40 rest home level residents, 10 hospital residents) is staffed with one-unit coordinator/RN Sunday – Thursday. One RN covers the AM shift with a second RN staffed the two days the unit coordinator is not available. One RN is staffed on the PM shift and one RN is staffed on the night shift. The AM shift is staffed with three short and three long shift caregivers, the PM shift is staffed with a senior caregiver, one short shift and one long shift caregiver, and the night shift is staffed with two long shift caregivers.</p> <p>Service apartments (6 rest home level residents) is staffed with one-unit coordinator/RN five days a week. An RN is rostered on the two days that the unit coordinator is not available. The AM is staffed with one long and one short shift caregiver, and the PM is staffed with two short shift caregivers (1600 – 2100). After 2100, the caregivers in the rest home wing (Himalaya) staff the serviced apartments. The serviced apartment call system is linked to their pagers.</p> <p>A ‘cover-pool’ of staff (three RN shifts and three caregiver shifts) are additional staff that are added to the roster to cover staff absences.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>PA Moderate</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurse and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (three hospital units, rest home, serviced apartments and dementia care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk supply order is maintained for hospital level residents. Eyedrops and ointments are dated on opening. The medication fridges and medication rooms are checked weekly and temperatures sighted were within the acceptable range. There was one rest home resident and one hospital level resident self-medicating on the day of audit. Medications were stored safely in the resident’s room. Three monthly self-medication competencies had been completed by the RN and authorized by the GP.</p>

<p>guidelines.</p>		<p>There were no standing orders. There were no vaccines stored on site.</p> <p>Eighteen medication charts were reviewed; three paper based (respite) and fifteen on the electronic medication system were. Medications are reviewed at least three-monthly by the GP for the long-term residents. The GP and the community mental health nurse review medications for dementia care residents. There was photo identification and allergy status recorded. As required medications had indications for use prescribed. The effectiveness of as required medications is recorded in the progress notes and on the electronic medication system. Medication administration observed complied with policy. However, not all medication was labelled.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The head chef oversees the procurement of the food and management of the kitchen. The food control plan has been verified and expires May 2021. There is a well-equipped kitchen, and all meals are cooked onsite. Meals are plated in the kitchen and taken to the dining rooms in hot boxes and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. 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 are monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder and on a whiteboard. There are snacks available at all times in the dementia unit. The four-weekly menu cycle is approved by a dietitian.</p> <p>All residents and family members interviewed were very satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys. Management liaise regularly with the head chef to monitor feedback and identify any areas for improvement.</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 registered nurse initiates a GP or nurse specialist consultation. Registered nurse interviewed state that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given).</p>

		<p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. The service wound champion reviews all wounds and wound plans on a regular basis. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. There were 66 wounds, noting that some residents have more than one wound. The wounds ranged from minor skin abrasions, skin tears, basal cell carcinomas (three), ulcers (nine) and 11 pressure injuries. There were ten facility acquired pressure injuries: one stage one, five stage two, three stage three and two unstageable (section 31 notifications were sighted). The DHB specialist input to care was documented for the unstageable pressure injuries. All of the residents with a pressure injury and the majority of resident with any other wound) had a documented dietitian review. The service has an action plan in plan around skin care/ pressure injuries.</p> <p>Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically.</p> <p>Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A team of six activity officers and lounge carers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The rest home is Monday to Friday and the dementia and hospital programmes are units are seven days a week.</p> <p>There is a weekly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home residents in serviced apartment can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>The service has a van for the rest home, dementia care and mobile hospital resident outings. Residents attend functions in the community such as the 'opportunity' monthly concerts and school productions. There are regular combined activities and celebrations held in the large lounges and atrium for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations</p>

		<p>under supervision.</p> <p>Activities in the dementia care units include triple A exercises, garden walks in the two courtyards and around the village, singing, happy hours, hand therapy, word games, knitting group and dancing. The men attend the combined units' men's group for activities and outings. Volunteers are gradually being reintroduced following Covid -19. The activity sent photos to families during lockdown and enabled zoom meetings for residents and families. Families interviewed welcomed this initiative and were very grateful.</p> <p>There are interdenominational church services held in the chapel with room visits as required. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated. Junior school children and Kapa Haka groups visit.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback though resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The eight long-term resident care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. The respite care resident does not require an evaluation of care. The RN completes a daily evaluation for respite residents. The multidisciplinary review involves the RN, GP, caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one-three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires on 17 August 2021.</p> <p>Maintenance requests are generated through the on-line system and closed off when completed or paper-based system after-hours. There is a monthly maintenance plan that includes environmental, building and resident equipment checks. Electrical equipment has been tested and tagged. Clinical equipment including hoists and weigh scales, have been calibrated. Hot water checks in resident areas are checked monthly as part of the planned maintenance schedule. Essential contractors are available 24/7.</p> <p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. Outdoor areas provide seating and shade. The external areas are well maintained.</p> <p>The caregivers interviewed stated they have the equipment required to safely provide the care documented in the</p>

		care plans.
<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 on the v-care system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There has been one outbreak since the last audit. In March 2020 there was a gastroenteritis outbreak. Public health was informed, and the outbreak managed well.</p> <p>There is resource information and plans around preparing for and managing Covid 19. An additional competency has been added to the training schedule on personal protective equipment. Staff are also required to complete a self-directed or on-site session on Covid 19. There are plentiful supplies of PPE.</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</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	CI	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The organisation continues to work towards becoming restraint-free.</p> <p>During the audit, there were no residents using enablers and three residents using restraints. This rating of continuous improvement remains.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>Each of the units has a medication room (hospital one, two and three, rest home and the dementia unit) Medications are stored securely, and all staff who administer medication have completed a medication competency. Staff were observed administering medication and all practices were safe. However, not all medication was labelled.</p>	<p>(i). Two resident inhalers were not named in the rest home. (ii).Two syringes containing medication for the syringe driver were not labelled, dated or named.</p>	<p>(i)-(ii). Ensure that all medication is labelled and dated</p> <p>60 days</p>

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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Falls in the rest home have remained below the Ryman threshold since August 2020. Two QIPs are in place to reduce the number of falls for hospital level residents.</p>	<p>Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits. Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: providing falls prevention training for staff; ensuring adequate supervision of residents; and encouraging resident participation in the activities programme; physiotherapy assessments for all residents; routine checks of all residents specific to each resident’s needs (intentional rounding); the use of sensor mats and night lights; two hourly toileting for residents at risk of falling, GP/pharmacy reviews and the implementation of a falls calendar that highlights the location and time of residents’ falls.</p> <p>Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The falls prevention programme has been reviewed monthly and is regularly discussed at staff meetings. A review of the data evidenced that the falls rate is below the Ryman benchmarked target (11/1000 bed nights) for rest home level residents with the average rate of 8.1/1000 bed nights (August 2020 to November 2020).</p>

<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>	<p>CI</p>	<p>Ryman has continued with a number of systems to ensure residents nutritional needs are met and the dining experience improved. 'Project delicious' has continued and there is dietitian input to all residents with fragile skin, a wound or special dietary need.</p>	<p>The four-week rotating seasonal menu continues to offer a variety of choices including three main dishes for the midday and two choices for evening meal including a vegetarian option. Gluten free meals are offered on the menu. Dietary needs are met through the project delicious menu options. The service has liaised with food suppliers to improve quality of suppliers including access to specialised pure foods for pureed options. The dining rooms (viewed) have been set up to reflect an ambience of relaxed dining as observed during mealtimes. Nurses stations have laminated cards giving direction to assist staff with expectations for meal services.</p> <p>Dietitian input was documented for all resident with fragile skin or a wound (as well as for specialised needs such as weight loss). The additional nutritional requirements for residents with wounds have been recognised by the service and, although not formally measured, the RNs and NP felt that wound healing was much improved.</p> <p>The most recent resident surveys document that satisfaction with meal services has continued to improve.</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>CI</p>	<p>No enablers and three restraints were in place for a facility that had an occupancy of 187 residents.</p>	<p>There were no residents who required an enabler and only three residents who required the use of restraint (one bedrails and two chair briefs). Strategies being implemented include mandatory staff education and training including staff competencies, encouraging at risk residents to spend time in the lounges, and anticipating residents' needs (eg toileting). Also, significant time is spent educating families about the benefits of not using restraint. Evaluation of these strategies and regular restraint meetings to review restraint usage has resulted in maintaining the previous rating of continuous improvement.</p>

End of the report.