

Bob Scott Retirement Village Limited - Bob Scott

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: Bob Scott Retirement Village Limited

Premises audited: Bob Scott

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: 25 November 2020 End date: 26 November 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 112

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

| Indicator | Description | Definition |
|------------------|--|---|
| | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Bob Scott is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital (geriatric and medical) and dementia level care for up to 116 residents in the care centre and rest home level of care for up to 30 residents in serviced apartments.

The service is managed by a village manager who has been in the role since July 2020. The Village manager is an experienced registered nurse with Management experience at Ryman. She is supported by a clinical manager who has been recently employed and has experience in a nurse leadership role at Ryman. The residents and relatives interviewed spoke positively about the care and support provided.

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

There were no improvements required from this audit.

Areas of continuous improvements were identified around falls minimisation, restraint minimisation 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. |
|--|--|--|

The service complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

Services are planned, coordinated, and appropriate to the needs of the residents. The village manager, and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

place, which includes in-service education and competency assessments. The resident and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

| | | |
|--|--|--|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Standards applicable to this service fully attained. |
|--|--|--|

There is a comprehensive information package for residents/whanau on admission to the service including a brochure specifically relating to the dementia unit. Registered nurses are responsible for each stage of service provision including assessments, risk assessments, care plans and evaluations, which are updated at least six-monthly. Care plans demonstrate service integration and the residents/family interviewed confirmed they were involved in both the initial care planning process and ongoing review.

Resident files include medical notes by the contracted general practitioner/nurse practitioner and visiting allied health professionals. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

Medication policies and processes reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines and have completed annual competencies and education. Medication charts are reviewed three-monthly by the GP/nurse practitioner (NP).

The activity team provides an activities programme which is varied and interesting for each resident group. The engage programme meets the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links and there are regular entertainers, outings, and celebrations.

The menu is designed by a dietitian at an organisational level. All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were satisfied with the meals and commented positively when interviewed. There are snacks available at all times.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. All bedrooms have ensuite, additionally there are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility with hallways and communal areas being spacious and accessible. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available.

There are policies, systems and supplies in place for essential, emergency and security services, including adequate civil defence/emergency water stocks. First aid trained staff members are on duty at all times.

Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site. Both departments have appropriate policies and product safety charts in place and quality standards are monitored through the internal auditing system. Chemicals are stored safely throughout the facility.

Restraint minimisation and safe practice

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

All standards applicable to this service fully attained with some standards exceeded.

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

Infection prevention and control

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

All standards applicable to this service fully attained with some standards exceeded.

The infection prevention and control programme include policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. Covid-19 screening was well managed, and documentation is held on record. Contact tracing remains in place. Adequate supplies of personal protective equipment were sighted throughout the facility.

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 | 2 | 43 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 3 | 90 | 0 | 0 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| 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 |
|---|-------------------|---|
| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Discussions with the village manager, clinical manager/RN, regional operations manager, and clinical staff (six caregivers, four registered nurses (RNs), three-unit coordinators (also RNs) and the activities coordinator) confirmed their familiarity with the Code. Non-clinical staff including one laundry staff, one lead chef, one regional chef, one housekeeper and a maintenance person were also familiar with the Code. The Ryman strategic staff aspirations link to the code including kindness and care, striving for excellence and communication. |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to | FA | The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all resident files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. The EPOA for the three-dementia level of care resident files reviewed, had been activated. Residents and relatives interviewed confirmed they were fully informed before providing consent. |

| | | |
|---|----|--|
| make informed choices and give informed consent. | | |
| Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. The resident files included information on residents' family/whānau and chosen social networks. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. Residents interviewed confirmed they are aware of their right to access independent advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community. | FA | The activities programmes included opportunities to attend events outside of the facility including activities of daily living, such as shopping. There is an on-site shop and hairdresser available. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has implemented the Ryman complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. The village manager investigates complaints in consultation with the clinical manager. Escalation of complaints to the regional manager is dependent on the severity of the complaint. A complaint register is maintained for all written and verbal complaints with dates acknowledged, actions taken, investigation and letters of outcomes or face-to-face meetings with the complainants. Complaints are being managed in a timely manner and within timeframes determined by the Health and Disability Commissioner (HDC). There were 13 complaints logged for 2020 year to date. All complaints documented a thorough investigation and follow up to the complainant. Complaints were documented as discussed in the facility meeting. Follow up to complaints included additional training as needed, discussion in meetings and one on one staff follow as needed. One complaint with the Health and Disability Commissioner for 2019 has been closed with no further action needed. |

| | | |
|--|----|---|
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>An admission information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. The village manager or the clinical manager discusses the information pack with residents/relatives on admission. Large print posters of the Code and advocacy information are displayed on noticeboards throughout the facility.</p> <p>Interviews with three hospital relatives, one rest home and three with a family member in the dementia unit as well as four hospital residents and two rest home residents confirmed that the services being provided are in line with the Code, and that information around the Code had been provided to them.</p> <p>Residents and relatives interviewed conformed there was the opportunity to discuss aspects of the Code during the admission process.</p> <p>Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. A tour of the service confirmed there were areas that support personal privacy for residents. Staff could describe definitions around abuse and neglect that aligned with policy. The caregivers were able to describe abuse and neglect and the service's zero tolerance policy. Staff have undertaken annual training on abuse and neglect.</p> <p>Residents and relatives' members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged.</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 a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. There are links with the local IWI – Arohanui Ki Te Tangata Marae. One Resident who identified as Maori stated that the staff were culturally safe as well as "lovely and respectful". The resident's cultural care was described well in the care plan.</p> <p>Team meetings document cultural considerations including Māori language week in TeamRyman meetings. Māori language week also features on the Engage programme.</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>Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on.</p> <p>The residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. Caregivers describe developing a rapport with residents and ask residents around individual preferences to provide optimum care. There were residents at the service who were unable to fully speak or understand English. Caregivers described using staff members and family to assist in translation. A self-directed learning package for cultural awareness was completed by staff as part of annual training.</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 responsibilities. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries.</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 policies and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>Registered nursing staff are available over seven days a week. The service receives support from the district health board which includes visits from specialists (e.g., wound care, mental health) and staff education and training. The clinical manager has previous experience in palliative care, infection control, and is the wound champion for the facility. Staff have the opportunity to be involved with health and safety.</p> <p>During the Covid19 period, the management reviewed options for an improved means of communication with staff so implemented the social media "Chattr" channel. Leaders were encouraged to touch base with their staff, asking how they were, how were things at home, checking to see if there was any extra support required, any members of the family unwell, and recognising that some partners had either lost hours of work, or had no work. Special Covid19 leave was instigated by the company so staff did not have to use their own leave. Staff were paid extra per hour during the level 4 lockdown. Vulnerable staff continued to be paid throughout the whole pandemic period. All staff were presented with a hamper of essential grocery items, this was to relieve the stress for staff working, and reduce the need to go to the supermarket. Counselling was offered to staff</p> |

| | | |
|---|----|---|
| | | which was free to those who wished to access this service. Staff working during the lockdown were provided with meals, provided with wellness packs containing masks, hand sanitizer, hand cream, vitamin C and paracetamol. Gift vouchers were gifted to all staff working to say "thank-you". Staff continue to be encouraged not to come to work if they are unwell. Additional sick leave has been provided, so staff feels secure not coming to work if they are unwell, and have no sick leave left. Special Covid19 sick leave codes were entered onto the roster system. |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | <p>Bob Scott is a Ryman Healthcare retirement village. The facility is across five levels. This includes 35 rest home level beds (dual-purpose) including one double-room on level four, 41 dual-purpose beds (dual-purpose) including one double room on level three and 40 dementia level beds (two 20 bed units) on level two. The service has 30 serviced apartments certified as able to provide rest home level care. Level one and level five are serviced apartments only. There are also serviced apartments across all floors. There were three residents receiving rest home care in the serviced apartments at the time of the audit. Occupancy during the audit was 112 residents in total (of 146 certified beds), 37 rest home level residents, including three in the serviced apartments, 40 hospital level residents (including one resident on respite care and one under 65 years). There were 35 residents across the two-dementia units.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Village objectives are documented, new objectives for 2020 include to improve standard of care and to improve meals. Objectives carried over from 2019 include to reduce staff turnover, improve laundry services, and improve activities. All objectives have action plans with evidence of monthly reviews and quarterly reporting on progress towards meeting these objectives.</p> <p>The village manager has been in the role since July 2020 (having been acting in the role since November 2019). The village manager is a registered nurse and was previously a clinical manager. The clinical manager has been in the role since May and was previously a unit coordinator.</p> <p>The village manager has attended in excess of eight hours education including Ryman village manager training days. The clinical manager has attended the senior leadership LEAP programme through Ryman and infection</p> |

| | | |
|--|----|--|
| | | control workshops. |
| Standard 1.2.2: Service Management 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. | FA | During the temporary absence of the village manager, the clinical manager would provide this role with support from the Assistant to the Manager and Ryman Christchurch team. |
| Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | <p>The Ryman quality and risk management system has been fully implemented at Bob Scott. A monthly team Ryman document is sent from head office to each facility directing tasks (such as internal audits, training and a monthly 'to do' list). Additional information includes new policies, changes, new staff and other information.</p> <p>Quality and risk performance is reported across the facility 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>All quality information (incidents and accidents, infection control and staff events as examples) are collated monthly and an analysis and report documented. All data is collated six-monthly to provide an in-depth analysis and trend. Quality plans are documented as needed and result present to facility meetings.</p> <p>Resident meetings are held two-monthly for each service level and relative meetings are scheduled six-monthly. The village manager attends the meetings, and minutes are maintained. Resident and relative surveys are 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>Internal audits are undertaken according to the set schedule. The service develops a corrective action plan for any audit result below 90%. A quality improvement register is maintained. Corrective actions are signed off</p> |

| | | |
|--|----|---|
| | | <p>when completed and audit results are communicated at the management and facility meetings.</p> <p>Resident and relative surveys are completed annually. Care centre resident survey results for 2020 had improved in all areas from 2019 survey results. The average score was 4.28 out of 5 which was an improvement from 2019. Survey results are communicated to residents, relatives and staff through meetings.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee who are representative of the facility. The health and safety representative is also the fire warden for the facility. There is a strong focus on identifying and reporting hazards. The risk register was last reviewed in September 2020. Ryman have initiated “step back” cards that are completed following every incident to analysis and identify the root cause. The noticeboard keeps staff informed on health and safety meetings. Head office sends out health and safety bulletins regularly and alerts for staff information and awareness. There are regular manual handling sessions taken by the physiotherapist.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contract a physiotherapist 20 hours a week who is supported by an employed physiotherapy assistant to carry out exercises and walks as directed by the physiotherapist. Care staff interviewed could describe falls prevention strategies as documented in myRyman care plans. The service has achieved a continuous improvement around falls minimisation.</p> |
| Standard 1.2.4: Adverse Event Reporting 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. | FA | <p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident, with immediate action noted and any follow-up action required. Neurological observations were completed for all unwitnessed falls and where there was the potential for a head injury. The incident reports reviewed document opportunities to minimise future risks.</p> <p>A review of twenty electronic incident/accident forms for the facility identified that all were fully completed and include timely follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings, providing an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify significant events that would be reported to statutory authorities, this has not been required since the previous audit.</p> |
| Standard 1.2.7: Human Resource Management Human resource | FA | <p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files were reviewed: (five caregivers, five RNs (including three-unit coordinators), a maintenance person, a housekeeper and an activities person). All included a signed contract, job description, police checks, induction, application form and reference checks. All files reviewed included</p> |

| | | |
|---|-----------|---|
| <p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>annual performance appraisals. A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice.</p> <p>A register of registered nurse's practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>There is an implemented annual education plan. Training is provided in a variety of ways including (but not limited to); Journal club, Rymans academy (online training) closing the loop (head office led skype training) and traditional group training sessions. Each month the service is informed, via Team Ryman regarding what education is to be provided as well as any resources needed. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Eight of twenty registered nurses including the clinical manager have completed their InterRAI training. Staff have completed the core competencies relevant to their role.</p> <p>Caregivers are encouraged to gain qualifications with the New Zealand Qualification Authority (NZQA). All staff who work in the dementia unit have completed their dementia unit standards.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The village manager and clinical manager work fulltime Monday to Friday and are on call 24/7. Each service unit in the care centre has a RN unit coordinator and an enrolled nurse unit coordinator for the serviced apartments.</p> <p>There is at least one RN and first aid trained member of staff on every shift. Interviews with caregivers informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated that overall, there was sufficient staff to meet resident needs.</p> <p>Staffing at Bob Scott is as follows.</p> <p>Level two, special care unit (dementia). There are two units of 20 beds each, with 35 residents total on the days of audit. A central nurse's station has oversight of both units.</p> <p>AM staffing; a unit coordinator and an RN. Five caregivers (three long and two short shifts) plus a lounge assist person. PM shift; one RN and four caregivers (two long and two short shifts), plus an extra 4pm to 8pm caregiver. There are three caregivers across the two units overnight.</p> <p>Level three. 40 dual service beds, with 40 hospital level residents on the days of audit.</p> <p>AM shift: One-unit coordinator and two RNs. Eight caregivers (four long and four short shifts) plus a fluid round person. PM shift; two RNs and seven caregivers (two long shifts, and five short shifts- two finish at 8 pm and</p> |

| | | |
|--|----|---|
| | | <p>the remainder at 9 pm), plus a lounge person 4pm to 8 pm. Night shift: one RN and three caregivers.</p> <p>Level four. 40 dual service beds, with 35 rest home level residents on the days of audit.</p> <p>AM shift: One-unit coordinator or RN. Four caregivers (two long and two short shifts). PM shift: A senior caregiver plus three caregivers (one long and two short shifts- one of which finishes at 9 pm). Night shift: two caregivers.</p> <p>Serviced apartments: Two caregivers for the AM shift and two caregivers for the PM shift. The afternoon shift staff leave at 10 pm after which the rest home staff maintain oversight.</p> |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident's individual record within 24 hours of entry. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files were protected from unauthorised access. Entries were dated and included relevant caregiver or registered nurse, including designation. The electronic system (myRyman) demonstrated service integration of resident records. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The admission agreements reviewed align with the requirements of the ARCC and provide for both long-term and short-term care. Exclusions from the service are included in the admission agreement. The service has a well-developed information pack available for residents/families/whānau at entry including specific information on dementia level of care and the safe environment. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made, with records evidencing that all appropriate documentation and communication had been completed. Transfer to the hospital and back to the facility post-discharge, is documented in the progress notes for those resident files showing hospital admissions. |

| | | |
|--|----|--|
| or transfer from services. | | |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | <p>Twenty-two medication files were reviewed (eight rest home, eight hospital and six dementia level of care) on the electronic medication management system. The medication management policies comply with medication legislation and guidelines. All required medication checks have been completed. Resident's medicines are appropriately and securely stored in accordance with relevant guidelines and legislation. Medication fridge and medication room temperature checks are conducted and recorded.</p> <p>Medication administration practice complies with the medication management policy for the medication rounds sighted. Registered nurses and caregivers administer medicines. All staff administering medicines have completed an annual competency and received medication management training. Care staff interviewed could describe their role in regard to medicine administration. The facility uses a blister pack medication management system for the packaging of all tablets. Expiry dates of medications are checked weekly. All eye drops and ointments were dated on opening. Two staff members (RN and medication competent caregiver) reconcile the delivery of new medication and document this with any errors fed back to pharmacy. There is evidence of three-monthly reviews by the GP.</p> <p>There is one rest home resident who self-administers some medicines. The resident self-administering their own medication has been assessed as competent to self-administer by the RN and GP. The resident's room was visited and confirmation that the medications were stored securely obtained. Standing orders are not used.</p> <p>Six medication charts were reviewed for dementia residents and identified minimal use of as required anti-psychotic medications.</p> |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | <p>All meals and snacks are prepared and cooked on-site. The qualified chef is supported by a cook and kitchen assistants. All staff have been trained in food safety and chemical safety. The service has a kitchen manual and a current food control plan verification. All residents have a dietary requirements chart completed on admission which is then shared with the kitchen to inform them of any resident likes, dislikes and dietary requirements. There is a four weekly seasonal menu that had been designed in consultation with company chef and the dietitian at an organisational level. Menu sheets are completed for individual residents for the week ahead. The menu offers two choices plus a vegetarian dish. Alternatives food choices are offered and provided as needed. There is evidence of modified diets being provided (e.g. diabetic menu) and further nutritional supplements. Meals are plated in the main kitchen and delivered to the units in hot boxes. Nutritious snacks such as sandwiches, fruit, yoghurts, baking and protein platters are delivered to the dementia care units daily.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily in accordance with the food control plan. Chilled goods temperature is checked on delivery. Twice daily food</p> |

| | | |
|---|----|--|
| | | temperatures are monitored and recorded. Perishable foods in the refrigerators are date-labelled and stored correctly. The kitchen is clean and has a good workflow. Chemicals are stored safely, and safety datasheets are available. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves. All kitchen staff have received appropriate food safety training. A cleaning schedule is maintained. Feedback on the service is received through direct feedback, resident meetings, surveys and audits. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whanau. 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 or needs assessment service for appropriate placement and advice. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Assessments of resident's needs, and abilities have been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI and other nursing assessments that indicated interventions required were reflected in the care plans reviewed. All electronic resident files reviewed showed assessment and evaluations carried out in a timely manner. Behaviour assessments had been completed on admission in the three dementia resident files reviewed. The outcomes of the assessments and de-escalation techniques were reflected in the behaviour management plans. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed demonstrated service integration and extensive input from other allied health professionals. Care plans were resident centred with support needs and interventions documented in detail to reflect desired outcomes and strategies available to staff to assist the resident to meet their care goals. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. The residents and family members interviewed stated they were involved in the care planning and review process. There were behaviour management plans in place for the three dementia care resident files reviewed. The behaviour management plans identified possible triggers and escalation/distractions including activities that could be successful in redirecting behaviours. |

| | | |
|---|----|--|
| <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> | FA | <p>Residents interviewed reported their needs were being met and the family members interviewed confirmed their relative's needs were being met appropriately. The electronic resident management system (myRyman) is a live document so any changes in a resident's condition can be documented and the plan of care altered in real time. This system supersedes the previously used system of short-term care plans. The registered nurse can also refer to senior staff and the GP/NP for advice/support as the resident's care needs dictate.</p> <p>Wound assessments, treatment and evaluations were in place for skin tears, six chronic ulcers and one non-facility acquired pressure injury for rest home and hospital level care. There were no residents in the dementia units with wounds or pressure injuries on the day of audit. The facility RN wound champion reviews all wounds weekly and works collaboratively with the local DHB wound nurse specialist. Sufficient dressing supplies are available on all floors and were sighted during audit.</p> <p>Residents have a three-day continence assessment as part of the admission process, which then documents strategies for continence management including toileting regimes or the type of continence product to be used and when, according to resident need. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>The electronic resident management system enables staff to enter monitoring data (weight, vital signs, neurological observations, food and fluid, restraint, pain, blood sugar levels and behaviour) at point of care in real time. Progress notes document changes in health and significant events.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>An identity map is completed by families for all residents admitted to the dementia care units. This information is used to develop the activity plan which is incorporated into the long-term care plan. Activity plans for dementia care residents include meaningful activities such as household chores including folding washing and gardening.</p> <p>A review of the activity programme confirms that independence is encouraged, and choices are offered to residents. The activity coordinators on each floor are responsible for delivering the Engage programme. The programme runs over seven days per week. The group diversional therapist signs off the core programme for each level of care, containing set activities to which each service level can add and tailor activities that are meaningful and relevant for the particular resident group such as mindbender for those residents with physical impairments but who still enjoy cognitive stimulation. A wide range of activities which support the abilities and needs of residents in the facility are provided and there are adequate resources available.</p> <p>Activities include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing.</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly.</p> |

| | | |
|--|----|---|
| | | <p>Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>Residents and family interviews confirm they enjoy the variety of activities and the majority are very satisfied with the activities programme. Activities include outings as well as community involvement.</p> <p>Regular meetings are held where residents and relatives have input. Minutes are recorded at the meeting and quality improvements identified and feedback given.</p> |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed have been evaluated by a registered nurse six-monthly. Care plans are evaluated to record progress towards achievement of the desired goals. Acute care interventions are evaluated as needed. The six-monthly multidisciplinary review involves the RN, GP, activities staff, resident/family and other allied health professional as appropriate. The family are notified of the outcome of the review if unable to attend and are able to receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirm they are invited to attend the care plan reviews and GP visits. |
| 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 sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The unit coordinators interviewed gave examples of where a resident's condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the clinical manager, unit coordinators and registered nurses indicates that the service has access to a wide range of support either through the GP, Ryman specialists, Mental Health Services, psychogeriatrician, hospice staff and other allied health professionals. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are | FA | There are policies and procedures in place for the storage and use of chemicals and to guide staff in waste management. Safety data sheets and product use information is available for staff. There are chemical spill kits readily accessible on each floor. There have been no incidents regarding chemical spillage or accidents. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Sluice rooms are available in each care level for the disposal of waste and hazardous substances. |

| | | |
|---|----|---|
| protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | | |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | <p>There are two 20-bed dementia care units separated by an adjoining door that can be opened for group/integrated activities or closed to provide a low stimulus dining/lounge area in one unit. Each unit has safe access to an outdoor deck area with raised gardens, shade and two entry/exit doors into the facility providing a walking pathway. There is a quiet lounge room in each unit. Lounge seating in both lounges is arranged for small group activities.</p> <p>The building has a warrant of fitness that expires 15 March 2021. The facility employs two maintenance staff and four gardeners. The maintenance staff ensure daily maintenance requests are addressed and the facilities manager has oversight of this. They maintain a monthly planned maintenance schedule which has been signed as completed (sighted). Essential contractors are available 24-hours. Electrical testing and annual calibration are carried out in accordance with the planned maintenance schedule. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors or contractors to the facility.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade are provided.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. The facility has two vans available for transportation of residents.</p> <p>Each dual-purpose unit has one double room suitable for couples. There are call bells by each bed and in the ensuite. There is ample space to provide care and privacy can be assured.</p> |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate | FA | All bedrooms in the rest home, hospital, dementia units and serviced apartments have full ensuites. Fittings and fixtures are made of easy clean surfaces that meet infection control practice. There are communal toilets located near to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. |

| | | |
|---|----|--|
| toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | | |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Bedrooms in all the units are spacious and of an adequate size appropriate to the level of care provided. The rooms in all areas allow for the resident to move about the room independently with the use of mobility aids. Those requiring hospital level care have sufficient space to allow for the easy manoeuvre of hoists, lazy boy chairs and other equipment required to safely deliver care. There is a double room for couples on the rest home floor and also one on the hospital floor. Residents and their families are encouraged to personalise the bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Residents have access to lounges, dining rooms and other communal areas throughout the facility which are easily accessible for those requiring mobility aids or staff assistance. Residents interviewed confirm there are areas available to them if they want to sit quietly or entertain others or if they don't want to participate in activities offered. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents in the dementia unit were observed to freely mobilise inside the unit and in the secure external garden area. All the corridors are wide with appropriately placed handrails. Residents interviewed state that they are happy with the dining and lounge facilities. |
| Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the | FA | The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. Dedicated cleaning staff are rostered on to clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. Dedicated laundry staff complete all laundry on-site in an appropriately appointed laundry which has an entry and exit door with defined clean/dirty areas. There is a secure area for the storage of cleaning and laundry chemicals for the laundry. The chemical provider monitors the use of chemicals and laundry processes. |

| | | |
|---|----|---|
| service is being provided. | | Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The service provides clothes labelling service for residents. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | <p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Orientation includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. Battery operated emergency lighting is in place which runs for at least two hours. The facility has three on-site diesel generators to run essential services. There is a civil defence kit located on each level. Supplies of stored drinkable water is stored in large holding tanks in addition to a supply of bottled water. There is sufficient water stored to ensure seven litres per day for three days per resident.</p> <p>The facility has an approved fire evacuation plan and fire drills take place six-monthly. The last fire evacuation drill occurred on 23 October 2020. Smoke alarms, sprinkler system and exit signs are in place. There are alternative cooking facilities available with three gas barbeques and gas hobs in the kitchen. Gas heaters are available if required.</p> <p>The call bell system is evident in residents' rooms, communal areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit. Sensor mats and call bell pendants were also observed to be in use serviced apartments, which are linked to staff pagers. The service has an electronic system at reception for all visitors including contractors to sign in and out. Staff advise that they conduct security checks at night, in addition to an external contractor. A security camera is installed at the entrance.</p> |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately ventilated and heated with underfloor heating. All rooms have external windows with plenty of natural sunlight. |
| Standard 3.1: Infection control management There is a managed | FA | The infection prevention and control programme is appropriate for the size and complexity of the service. There is an infection prevention and control responsibility policy that included a chain of responsibility and an infection prevention and control coordinator's job description. The clinical manager is responsible for infection |

| | | |
|--|----|--|
| <p>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>prevention and control at the facility and has previous experience in infection control coordination.</p> <p>The infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the TeamRyman calendar. The facility had developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. Notices are displayed on entry to the facility reminding visitors not to visit if they are unwell.</p> <p>Due to current Covid-19 guidelines, all visitors and contractors must complete a wellness declaration and sign into the facility. There were adequate supplies of infection control equipment sighted in the case of outbreaks. A good supply of hand gel, masks and aprons are available.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control updates. Ryman is a member of Bug Control. The IC coordinator is a member of the New Zealand wound care society and the infection control society New Zealand. The infection control team is representative of the facility. Resident care plans reviewed included comprehensive documentation for any known infections.</p> <p>External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>The requirements during the Covid-19 lockdown and practices at all different levels have been adhered to. There are folders containing all information and processes for each level of lockdown. During the lockdown period, staff were provided with separate changing facilities. All staff had very clear guidelines on infection control and laundering of uniforms. Residents adhered to the isolation and temperature checking. Activities were set up in hallways so residents could participate while adhering to social distancing. Education sessions were provided for hand washing and infection control. The correct techniques of donning and doffing personal protective equipment (PPE), and the outbreak drill procedure were provided. The facility continues to maintain current regulations, ensuring all visitors complete the electronic wellness declaration and sign in. Staff interviewed stated they felt well looked after and were well informed of changes during the Covid-19 period.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the</p> | FA | <p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p> |

| | | |
|--|----|---|
| <p>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>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings.</p> |
| <p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | CI | <p>The surveillance policy described the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer use the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection rates are benchmarked across the organisation. Bob Scott have earned a continuous improvement rating for the reduction of infections.</p> <p>There have been no outbreaks.</p> |
| Standard 2.1.1: Restraint | CI | <p>The restraint approval process is described in the restraint minimisation policy. The restraint officer is a registered nurse and the hospital unit coordinator. There is a job description that defines the role and</p> |

| | |
|---|---|
| minimisation Services demonstrate that the use of restraint is actively minimised. | responsibility of the restraint officer. The restraint approval group identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The approval group meet six-monthly when restraint is in use. There have been no restraints or enablers in use since September 2020. The service has been successful in reducing restraint and becoming restraint free. |
|---|---|

Specific results for criterion where corrective actions are required

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

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

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

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

Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|-------------------|--|---|
| Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Falls have reduced for hospital level residents over the past six months and have remained low (below the threshold) for the 2020 year for hospital level residents. | 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: highlighting residents at risk, 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; and increased staff awareness of residents who are at risk of falling. A high level of falls prevention training was initiated including: risk factors for falls and fall prevention strategies. The service took a holistic view of falls prevention and included nutrition, continence, medications, and medical conditions. Addition equipment such as sensor mats were also purchased. 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 hospital level residents since December 2019 with a reducing trend. |

| | | | |
|---|----|---|--|
| | | | Hospital falls were 15 per 1000 bed nights November 2019 and were six per 1000 bed nights October 2020. |
| Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | Infections are included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. Infections are benchmarked across Ryman and quality action plans are identified where infections are above the benchmark. The service has been successful in reducing the number of urinary tract infections and respiratory infections. | The IC team at Bob Scott identified to better manage infection control and reduce the incidence of urinary tract infections, reduce the use of anti-microbials and reduce respiratory infections. Quality initiatives were implemented for both the reduction of UTIs and for respiratory tract infections. Strategies for the reduction of UTIs were documented and implemented including (but not limited to): staff reminders at handover regarding encouraging fluids, more choice of fluids for residents, smoothies made in the kitchen so they were more available for residents, ice blocks in warm weather, and jellies as an alternative to fluids. Additional in-service education was provided to staff and a higher focus in clinical (and other meetings) around UTIs and the need for fluids. Monthly and six-monthly evaluation of the project was documented well. The project also linked in with the DHB initiative for the reduction of antimicrobials. The GP was involved, and a clinical pathway initiated for those residents at risk of or with re-occurring UTIs. As a result of the project the incidence of UTIs at Bob Scott has remained at nil for all but two months since May 2019. A similar process was implemented for the reduction of respiratory tract infections. The quality plan also included the prevention of cross infection with an emphasis on hand hygiene, and surface cleaning (bench tops, doorknobs and keypads as examples). Education included cough etiquette, use of PPE, and encouraging the flu vaccination. As with the UTI project clinical meetings, handovers, and other meetings discussed respiratory infections ensuring staff were all up to date on best practice. Monthly and six-monthly reviews were documented. As with UTIs respiratory infections have reduced since July 2019 (five per 1000 bed days) to between nil and one since November 2019. |
| Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the | CI | In April 2020 the service aimed to reduce the amount of restraint use and work towards becoming restraint free. In September 2020 the service achieved its goal of being restraint free. | In July 2019, there were three hospital residents with chair brief restraints. There have not been any residents in the dementia care units requiring restraint. The restraint officer developed an action plan to reduce restraint in consultation with the restraint approval group, clinical manager, GP, physiotherapist and activities team. The activities team developed individual plans for the residents on restraint to engage them in activities throughout the day. The action plan was discussed with |

| | | | |
|--|--|--|--|
| needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | | | <p>RNs and caregivers at facility meetings. Education was provided around restraint minimization, management of challenging behaviour, behaviour and psychological symptoms of dementia and behaviour is a form of communication. Each of the three residents on restraint had a medical review, physio review and reviewed activity plan in place prior to the trial of removal of restraint. Intentional rounding was tailored to meeting the residents needs and scheduled on the caregiver/RN work schedule. Relatives were fully informed and consented to trial of removal of restraint. Over a seven-month period from January 2020 to August 2020 the service successfully trialled a removal of restraint for three residents. There had been no incidents related to trial of removal of restraint. There had been no further residents added to the restraint register. The service has become restraint free and is ranked # 1 in the Ryman group for a restraint free facility.</p> |
|--|--|--|--|

End of the report.