

Evelyn Page Retirement Village Limited - Evelyn Page Retirement Village

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:	Evelyn Page Retirement Village Limited
Premises audited:	Evelyn Page 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: 19 November 2020 End date: 20 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:	123



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

Ryman Evelyn Page provides rest home, hospital (geriatric and medical) and dementia level care for up to 147 residents. On the day of audit there were 123 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

The village manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse) who oversees the care centre. There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

This certification audit identified an improvement required in relation to neurological observations.

There is one continuous improvement awarded around pressure injury prevention.

Consumer rights

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

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, clinical manager and unit coordinators are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

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

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

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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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 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 practitioner 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 activity coordinators implement the activity programme 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 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 on the standard of the meals provided. 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.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is a person on duty at all times with first aid training.

Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained by the restraint coordinator. During the audit fourteen residents were using restraints and three residents were using enablers.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control coordinator has completed training in 2020. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. Information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control. There has been one outbreak since the last audit with this managed with support from relevant external providers.

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	48	0	1	0	0	0
Criteria	1	99	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code)). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as part of their annual in-service programme and competency assessment.</p> <p>Interviews with 24 staff (seven caregivers on the am, pm and night shifts [one serviced apartment, two dementia unit, four rest home/hospital]); seven nursing staff (three-unit coordinators/registered nurses [RNs], and four RNs); one head chef and four kitchen staff; two laundry, one health and safety officer and two activity coordinators, confirmed their understanding of the Code.</p> <p>Staff interviewed could provide examples of how the Code applies to their job role and responsibilities. Nine residents (six rest home including one serviced apartment and three hospital) and 12 relatives (one rest home, eight hospital and three dementia) interviewed confirmed that staff uphold the rights of residents.</p>
Standard 1.1.10: Informed Consent	FA	Informed consent processes are discussed with residents and families on admission and are

<p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>included in the admission agreement. Specific consents were viewed for wound photographs and influenza vaccines. Twelve resident files reviewed (three rest home including one resident in a serviced apartment, five hospital level of care residents including one using respite care, and four two dementia level of care residents) included written consents.</p> <p>Advance directives and/or resuscitation status are signed for separately by the competent resident. Where the resident is unable to decide, the GP makes a medically indicated not for resuscitation order in consultation with the enduring power of attorney (EPOA). The EPOA for the four-dementia level of care residents had been activated. Copies of EPOA and activation status are available in the resident's file. Caregivers and registered nurses (RN) interviewed confirmed verbal consent is obtained when delivering cares. Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Admission agreements for the residents including the resident using respite reviewed had been signed within a timely manner.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with family confirmed the service provides opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and families interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain actively involved in community and external groups. Families and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission and on noticeboards. Interviews with residents and family members confirmed their understanding of the complaints process. Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction. Staff interviewed were able to describe the process around</p>

		<p>reporting complaints.</p> <p>A complaint register is in place. The following complaints are documented as having been received in 2020: a total of five (two lodged from residents or family from the hospital and three from the dementia unit). These complaints were investigated and resolved within timeframes determined by the Health and Disability Commissioner. There is evidence of the themes from the complaints discussed in staff and management meetings with appropriate follow-up actions taken.</p> <p>The complaints process is linked to the quality and risk management system. All complaints are identified as being closed out.</p> <p>There have not been any complaints from the Health and Disability Commission or other external providers since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Aspects of the Code are discussed during the admission process with the village and/or clinical manager. Residents and relatives interviewed confirmed that information had been provided to them about the Code. Large print posters of the Code and advocacy information are visually displayed throughout the facility on noticeboards.</p> <p>Families and residents are informed of the scope of services and any liability for payment of items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms and closing doors while cares were being given. Staff interviewed were able to define abuse and neglect and its application to an aged care environment. Residents and relatives interviewed confirmed that staff respected resident privacy.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident care provision particularly in the dementia unit. Examples of giving choice were described.</p> <p>Instructions provided to residents on entry regarding responsibilities of personal belongings is in their admission agreement.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has implemented a Māori health plan. The service has links with Silverdale marae and Orewa College kapahaka group. Staff have attended training on the marae which has supported their understanding of working with Maori.</p> <p>There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the resident's care plan. At the time of the audit, no residents identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau are invited to be involved. Individual beliefs and values are also discussed and incorporated into the resident's care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with residents and family confirmed that residents' values and beliefs are considered.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include the role and responsibilities of the position. The monthly full facility meetings include discussions on professional boundaries and concerns as they arise. Interviews with managers (village manager, clinical manger, assistant to the manager, regional manager) and staff, confirmed their awareness of professional boundaries. Forty-nine staff have completed training on unconscious bias in February 2020 and 87 staff have completed training around bullying and wellbeing in August 2020. There were no incidents or complaints identified since the last audit around discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data is collected for each service level. It is reported through to Ryman Christchurch for collating, monitoring, and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type. Feedback is</p>

		<p>provided to staff. Quality improvement plans (QIPs) are developed where results do not meet acceptable targets. Work continues around reducing workplace injuries by 10%, as compared to 2019; to improve the knowledge of RN's in identified areas; and to provide a greater range of activities for residents in serviced apartments.</p> <p>A recent staff satisfaction survey reflected a ranking of 6 out of a total of 34 care centres with a 94% response rate. This positive outcome has been shared with the staff and the residents. Areas highlighted as strengths included: keeping people safe and well at work; person they report to is approachable; they were informed about Ryman's Covid 19 response plan, there is an organisational commitment to staff general wellbeing. A resident satisfaction survey has not been completed yet. Courtesy calls were recently undertaken with positive results and feedback.</p> <p>The myRyman electronic resident information (e.g., care plans, monitoring charts) have been implemented that allow for one-on-one time with residents and less paper-based documentation. Interventions (e.g., weight management, falls management strategies, pain management, neurological observations, behaviour management) documented on myRyman are reviewed by a registered nurse. MyRyman care plans provide evidence to indicate when cares are being delivered.</p> <p>A general practitioner or nurse practitioner visits the facility three times a week with 24/7 on-call services. Physiotherapy services are provided five days a week for a total of 20 hours. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists.</p> <p>The health and safety programme has introduced a 'stop and think' employee campaign using 'step-back' cards. Staff are involved in identifying risks and hazard controls.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Twelve adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p> <p>Three of nine residents interviewed raised individual issues related to staff directing their care and choice. One of the 12 relatives interviewed also expressed some concerns related to staff attitude. On the whole however, residents and family are very satisfied with all aspects of service delivery and the positive feedback outweighed the small proportion of concerns raised.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Evelyn Page is a Ryman retirement village located in Orewa. The service is certified to provide rest home, hospital (geriatric and medical) and dementia level care in their care centre for up to 117 residents. In addition, there are 30 serviced apartments certified to provide rest home level care.</p> <p>There are 40 dual-purpose beds on the ground level, 40 dual purpose beds on level one and 30 serviced apartments (only able to take rest home residents) with a total of 25 residents requiring rest home level of care (including seven in the serviced apartments requiring rest home level of care) and 62 requiring hospital level of care. There are two secure care (dementia) units (19 bed and 18 bed unit) with 36 occupied beds on the day of audit. There are two residents using respite level of care (one requiring hospital level of care and one rest home resident). There is one resident who is under 65 years of age (on a 'of like and interest' contract) in the secure care unit.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Organisational objectives are documented with evidence of monthly reviews and quarterly reporting on progress towards meeting these objectives.</p> <p>The village manager has two years aged care experience, three years' experience in management prior to this in education, has a master's Advanced Leadership Practice, and educational management employed by Ryman since August 2018. She has previous managerial experience and has recently completed a master's degree in leadership and has attended over eight hours of professional development activities related to managing an aged care facility within the past 12 months. The village manager is supported by a regional manager, an assistant manager, and a clinical manager/RN.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually, specific to Evelyn Page. Each objective includes an action place and person(s) responsible. There are specific projects with action plans related to a focus on reducing staff injuries, increasing registered nurse knowledge on specific areas, improving the activities programme and encouragement for staff to multi-skill. Details of progress is reported quarterly.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	<p>FA</p>	<p>The clinical manager assumes responsibility during the temporary absence of the village manager with additional support provided by the regional manager (registered nurse and village manager at another site). The unit coordinators (UCs) are responsible for clinical operations during the temporary absence of the clinical manager. The clinical manager is a registered nurse with 14 years' experience in aged care.</p>

services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management system that is directed by head office (Ryman Christchurch) is established and implemented. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with managers and staff, and the review of meeting minutes demonstrated the collective involvement of managers and staff in quality and risk management activities.</p> <p>Resident meetings are held bi-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>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.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is intended to be used for service improvements. Results are communicated to staff across a variety of meetings including (but not limited to) monthly staff, registered nurse, management, health and safety meetings and three-monthly caregiver meetings. The internal audit programme is followed as per the schedule. Quality improvement plans are documented when issues are identified.</p> <p>There is an annual satisfaction survey completed. The relative survey for the care centre completed in October 2020 showed the lowest scores being around food and linen. The care centre resident survey completed in June 2020 had a net promoter score of five (down by 28). Improvements required to food have resulted in a corrective action plan being put in place with actions already showing satisfaction from residents.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Meetings are held monthly with infection control meetings held bimonthly. Health and safety data is tabled at staff and management meetings. The health and safety officer (activities coordinator) interviewed was able to describe their role as per policy and three caregivers interviewed stated that they had seen the health and safety officer regularly completing site tours to look for any issues. 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</p>

		<p>to the service and staff. A review of the risk register and the maintenance register indicated that there is resolution of issues identified. All new staff and contractors are inducted to health and safety processes. There is also annual in-service training and competency assessments.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls with a range of examples provided (e.g., providing falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; 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).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise, and debriefing. Individual incident reports are completed electronically using VCare for each incident/accident with immediate action(s) and any follow-up action required evidenced.</p> <p>A review of 16 incident/accident reports (including witnessed and unwitnessed falls, skin tear, challenging behaviour) included follow-up by a registered nurse. There was inconsistent evidence of timely neurological observations if there is a suspected injury to the head or an unwitnessed fall (link 1.3.6.1).</p> <p>The managers and unit coordinators are involved in the adverse event process via regular management meetings and informal meetings during the week that provide an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations would be reported to statutory authorities. Two Section 31's have been lodged with the Ministry of health since the last audit. One was for a missing resident and one was for a sudden death when the GP did not in the death certificate in a timely manner.</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</p>	<p>FA</p>	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation, and staff training and development.</p> <p>There are 146 staff employed in the service. Thirteen staff files were selected for review (five caregivers, one clinical manager, two-unit coordinators, one head chef, three RNs, one activities coordinator). Each file included an application form and two reference checks, a signed employment contract, job description, police check, and completed orientation programme. All files reviewed also</p>

<p>of legislation.</p>		<p>included an annual performance appraisal.</p> <p>A register of registered nurses current practising certificates are held on site. Practicing certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. The general orientation programme that is attended by all staff covers 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 complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. RNs are supported to maintain their professional competency. Eight of 19 RNs 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. There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies.</p> <p>There are 26 HCAs who have completed their unit standards in dementia; 11 who have completed a national certificate core competency or foundations or residential; and 23 HCAs who have level 7 – diploma in health services management. Staff who work in the dementia unit have completed the relevant dementia training.</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 (Monday – Friday), assistant to the manager and clinical manager (Tuesday – Saturday).</p> <p>There are four-unit coordinators (one hospital/RN, one rest home/RN, one dementia/RN, one serviced apartments/overseas RN) work full time.</p> <p>Staffing is as follows:</p> <p>Rest home ground floor (19 rest home, 22 hospital): one registered nurse in the morning, afternoon, and night; six caregivers (including three on a short shift) in the morning and five in the afternoon (including two short shift) with two caregivers overnight.</p> <p>Hospital/rest home (level one- 40 hospital residents): two RNs in the morning and afternoon and one</p>

		<p>overnight; eight caregivers in the morning (four short shift); six caregivers (four short shift in the afternoon; and three caregivers overnight. There is also a staff member from Monday to Sunday (0930AM-1PM) who gives out fluids and helps with mealtimes and a lounge carer in the afternoon from 4PM-8PM.</p> <p>Dementia units (18 residents in each unit): There are two RNs in the morning (one in each unit) and one in the afternoon (across the two units); four caregivers (three long shift and one short) in the morning; one registered nurse in the afternoon with four caregivers (two caregivers from 3PM-9PM, one from 4PM-9PM and one long shift) and one lounge carer; and one senior caregiver and two caregivers overnight.</p> <p>(Seven rest home residents in serviced apartments). There is a minimum of one senior caregiver on duty in the serviced apartments during the night shift, with additional staffing on the morning and afternoon shifts. Staffing throughout the facility meets contractual requirements and is adjusted based on the number of residents and their acuity.</p> <p>Staff were visible during the audit and were attending to call bells in a timely manner, as confirmed by all residents and families interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p> <p>The clinical manager and unit coordinators manage the on-call roster.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident information (hard copy and electronic) is protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation. Residents' files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. Family members and residents interviewed state that they have received the information pack and have received sufficient information prior to and on entry to the service. Specific information about the dementia unit (SCU) is provided to families. Family members report that the village manager or clinical manager are</p>

		available to answer any questions regarding the admission process
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. 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. One file reviewed was of a resident who had been transferred to hospital acutely post fall. All appropriate documentation and communication had been completed. Transfer to the hospital and back to the facility post-discharge, is documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Twenty-five medication files were sampled (six rest home, eleven hospital and eight dementia level of care). 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 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 medication competent caregivers administer medicines. All staff administering medicines have received medication management training and successfully completed a medication competency which is reviewed annually. The facility uses a blister packed medication management system for the packaging of all tablets. Registered nurses reconcile the delivery of new medication and document this in the electronic medical system. There is evidence of three-monthly reviews by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is managed by the village head chef and a sous chef who oversee the kitchen team in the preparation and cooking of meals. The service has a food control plan. A four-weekly seasonal menu is implemented. A dietitian has reviewed and approved the menu. All residents have their dietary requirements and/or preferences documented on admission.</p> <p>The chef receives a copy of each resident's dietary requirements that include likes/dislikes and regularly visits residents on each floor to seek feedback.</p> <p>Alternatives food choices are offered and provided as needed. There is evidence of modified diets being provided (e.g. pureed menu) and further nutritional supplements. There is snacks available for</p>

		<p>dementia residents, confirmed at staff interviews. Availability of extra snacks and meals outside of normal mealtimes was confirmed by a relative during interview.</p> <p>Residents and relatives interviewed confirm likes/dislikes are accommodated and expressed their satisfaction with the food service. Fridge and freezer temperatures are recorded daily. 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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available. If a potential admission was declined entry, the consumer and where appropriate their family/whanau member of choice, is informed of the reason for the decline and advised to contact the needs assessment service (NASC).</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Initial interRAI assessments and reviews are evident in printed format in all resident files. Resident files reviewed identify that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The resident care plans in myRyman are personalised and describe the resident's goals, supports and interventions required to meet those desired goals, as identified during the ongoing assessment process. The care plan acknowledgement form evidence resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview that they and their families are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. All long-term care plans sampled have been reviewed and updated in a timely manner following a change in need. Integration of records and monitoring documents are well managed.</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>PA Low</p>	<p>Registered nurses (RNs) and caregivers follow the care plan detailed on myRyman and report progress against the care plan each shift at handover. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the dietician, physiotherapist or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Continence products are available and resident files include a three-day continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, treatment and wound management plans are completed for all wounds. On the day of audit there were fourteen wounds. These included: four skin tears, two ulcers, one laceration, six abrasions and one surgical wound. All wounds have been reviewed within appropriate timeframes. All wounds evidence progress towards healing with the exception one of the chronic ulcers. Wound nurse champion and GP input is evidenced for all wounds, with referral to other allied health professional as required.</p> <p>The GP was positive regarding the service, the staff and the clinical interventions. The GP described Evelyn Page's involvement with advanced care planning, linking with the hospice. The DHB/ hospice initiative is a service that is developed with the residents prior to the palliative phase. Its aim is to ensure all vital services, and resources are in place and residents and their families are well prepared. The GP praised Evelyn Page's proactive involvement with the service.</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p> <p>Neurological observations are expected to be taken for all unwitnessed falls within the timeframes outlined by Ryman policy, however this was not always documented.</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 review of the activity programme confirms that independence is encouraged, and choices are offered to residents. Three activity coordinators at Evelyn Page deliver the programme. One is a qualified diversional therapist, and one is about to commence diversional therapy training. The programme runs over seven days per week. A wide range of activities which support the abilities and needs of residents in the facility are provided with each floor of the building having its own monthly activities schedule.</p> <p>Activities included physical, mental, spiritual and social aspects of life to improve and maintain</p>

		<p>residents' wellbeing.</p> <p>On admission, an activity coordinator completes an assessment for each resident and a resident life experiences form which are utilised as part of the care planning process. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition change) as part of the care plan evaluation/review. In the dementia files reviewed, residents have an activity plan that document activities that can be utilised to de-escalate challenging behaviours, which are specific to individual residents.</p> <p>Residents and family interviews confirm they enjoy the variety of activities and are very satisfied with the activities programme. Activities include outings as well as community involvement.</p> <p>A monthly meeting is held where residents and relatives have input. Minutes are recorded at the meeting and quality improvements identified and feedback given</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed have been evaluated six-monthly by a registered nurse. Care plans are evaluated to record progress towards achievement of the desired goals. Acute care needs are documented in myRyman and evaluated as needed. The six-monthly multidisciplinary review involves the RN, GP, activities staff, physiotherapist (if involved) and resident/family. The family are invited to discuss the outcome of the review, and if unable to attend, they 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.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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 coordinator 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 unit coordinators and registered nurses identified that the service has access to a wide range of support either through the GP, Mental Health of Older Persons Services, geriatrician and hospice staff.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets were available.</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>	<p>FA</p>	<p>The facility has three service levels across three floors. The serviced apartments are accessed from the ground floor. There are multiple lifts and stairs access between the levels and secure entrance and exits to the dementia unit.</p> <p>The building has a current building warrant of fitness that expires 6 December 2021.</p> <p>The facility employs two maintenance staff (full-time and on-call) and gardens and grounds staff. Daily maintenance requests are addressed, and a 12-monthly planned maintenance schedule is in place and has been signed off monthly (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise safely using mobility aids.</p> <p>Residents were observed safely accessing 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 cares as outlined in the resident care plans.</p> <p>Both dementia care units include an open plan dining/lounge area. There is a partitioner between the two-unit lounges that can be open for joint activities. There is free and safe access to an outdoor deck area with raised gardens, seating and shade.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal</p>	<p>FA</p>	<p>All bedrooms are single occupancy and have ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	Residents rooms are of an appropriate size in all areas to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Bedrooms are personalized. Bedroom doors in the dementia unit have door photographs to aid resident identification of their room
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	Each unit has a small kitchen and dining area. Large lounges have seating placed to allow for individual or group activities. There is a smaller lounge/library area and seating alcoves in the hospital and other areas. The communal areas are easily accessible. The dementia care units have spacious open plan dining/lounge areas with seating placed appropriately to allow for low stimulus, small group and individual activities. There is a smaller family/whānau lounge for quiet activities or family visits. The communal areas in the dementia unit are easily and safely accessible for residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the internal audit programme. All linen and personal clothing is laundered on-site. The laundry had an entry and exit door with defined clean/dirty areas. There are multiple areas for storing cleaning equipment. There are dedicated cleaning and laundry persons on duty each day.</p> <p>There are secure areas for the storage of cleaning and laundry chemicals for the laundry on each floor.</p> <p>Resident and family interviewed reported increased satisfaction with the laundry service. The service was observed to be clean and well maintained.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills take place six monthly. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting and cooking facilities are in place. There are civil defence

<p>emergency and security situations.</p>		<p>kits in the facility and stored water on site.</p> <p>The call bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advise that they conduct security checks at night, in addition to an external contractor.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately ventilated and heated, with under floor heating. All resident rooms on the external sides of the building and on level three have a window to the outside. Resident rooms on the inside have a window opening into the large atrium. The atrium provides natural light through the glass roof. Two residents, (including one in a corner room with foliage outside the room window) in the internal rooms sated they are very happy with their room.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. Responsibility for oversight of infection control across the facility is the responsibility of a registered nurse (interRAI trained). The RN has been in the role for two years (10 years at Evelyn Page as a registered nurse) and was able to describe the role as per the job descriptions.</p> <p>The infection prevention and control committee meet two monthly and comprise of a cross section of staff. The infection control coordinators provide monthly reports to head office and to the full facility meetings.</p> <p>The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and a six-month analysis is completed by the infection control coordinator and reported to the governing body.</p> <p>All visitors and contractors are required to complete an electronic health declaration which also serves as contact tracing. Residents and staff are offered the annual influenza vaccine. All staff are now asked to have an influenza vaccine prior to commencing work at Ryman as part of the Ryman initiative against Covid 19. Residents transferring from hospital or the community are placed in isolation for 14 days. There are adequate hand sanitisers and signage throughout the facility. There is an outbreak management bin and plentiful stock of personal protective equipment (PPE) that is checked weekly. There is sufficient PPE to last at least for two weeks.</p>
<p>Standard 3.2: Implementing the</p>	<p>FA</p>	<p>The infection control coordinator completed the infection control induction on appointment to the roles and attended an annual external education programme (March 2020) with a microbiologist via</p>

<p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>teleconferencing.</p> <p>The facility has access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory, and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. There is resource information and plans around preparing for and managing Covid 19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinators are responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions, and training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits six monthly. In-services have been provided around personal protective equipment and outbreak management. Infection control is an agenda item on the full facility and clinical meeting agenda. 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.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files.</p>

<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Infections are included on an electronic register and the infection prevention coordinators complete a monthly report. Monthly data is reported to the infection control committee with trends analysed and analysis of data for each area. Meeting minutes are available to staff. Staff are informed of surveillance through the variety of clinical meetings held at the facility.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking against other Ryman facilities occur. Quality improvements are commenced for any areas identified for improvement.</p> <p>There has been one outbreak in June 2019. Appropriate external providers were notified including the GP and public health services, and the outbreak contained to a small number of residents and staff. Data was reviewed and any opportunities for improvement considered in a review of the outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were eight hospital level residents with restraint (chair briefs and bedrails) and six residents at rest home level with restraint (chair briefs and bedrails). There were three residents with an enabler: two in the rest home and one in the hospital- all bedrails.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

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

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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Progress notes documented intentional rounding and RN follow up, however neurological observations were not consistently carried out according to the Ryman policy timescales.	Twelve incident forms were reviewed. Seven incidents required neurological observations. Out of the seven, six incidents did not have neurological observations completed as per Ryman policy requirements.	<p>Complete neurological observations as per Ryman policy requirements</p> <p>90 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has continued to maintain clinical care that has resulted in no facility acquired pressure injuries.</p>	<p>There are no pressure injuries in the service. Staff have implemented a number of ongoing strategies that include intentional rounding for residents identified as being at risk of having a pressure injury; use of the Waterlow assessment tool on admission and as required. Residents skin is inspected daily when daily cares are provided. Care staff have received ongoing education around assessment of skin, adequate hydration, and pressure minimisation. The nutritional status of each resident is monitored with referral to a dietician if a resident is identified as having weight loss (2.2kgs or more), at risk of pressure injuries, or if there is gradual weight loss which could increase the risk of pressure injuries. Moisturisers are used daily or more frequently if required. There is evidence of proactive and skin changes are referred to the registered nurse for assessment and monitored by the wound care champion. One resident who was interviewed stated that the clinical manager had sighted specific areas of concerns at least daily to check for changes or potential pressure injuries. Trends are analysed with data for Evelyn Page benchmarked against Ryman facilities. The service remains in the lower 10 percentile of the Ryman group average for facility acquired pressure injuries.</p>

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End of the report.