

# Yvette Williams Retirement Village Limited

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Yvette Williams Retirement Village Limited	
<b>Premises audited:</b>	Yvette Williams Retirement Village Limited	
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 1 February 2021	End date: 2 February 2021
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	90	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Yvette Williams is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital and psychogeriatric level care for up to 122 residents. On the day of the audit, there were 90 residents.

This unannounced surveillance audit was conducted against a sub-set of 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 the general practitioner.

The village manager is appropriately qualified and experienced and is supported by a clinical manager/registered nurse, unit coordinators and a team of experienced staff. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

This surveillance audit identified the service is meeting the health and disability standards.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

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

## Organisational management

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

A comprehensive quality and risk management programme is embedded. 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 for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week, twenty-four hours a day. Residents 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.
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The registered nurses' complete assessments, care plan development and evaluations within the required timeframe. Care plans demonstrated service integration. Monitoring forms were being utilised. Care plans were updated for changes in health status. Resident and relatives interviewed confirmed they were involved in the care plan process and review.

The activity and lifestyle team provides an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community. There were 24-hour activity plans for residents in the special care psychogeriatric unit that were individualised for their needs.

Staff responsible for medication administration have completed annual competencies and education. Medication is appropriately stored, managed, administered and documented in line with current guidelines.

All meals are prepared on site. A dietitian designs the menu at an organisational level. Individual and special dietary needs are catered for. Nutritional snacks are available 24-hours for residents in the psychogeriatric unit. Residents interviewed responded favourably to the food provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. A building systems status report (BSSR) has been issued in place of an updated building warrant of fitness following missed inspections over the Covid-19 lockdown.

The maintenance person attends to any maintenance requests or can call in contractors as required. There is a 12-monthly planned maintenance schedule in place.

External areas are safe and well maintained with shade and seating available.

## Restraint minimisation and safe practice

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

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	42	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with five residents (three hospital level and two rest home level [one rest home, one serviced apartment]) and family confirmed their understanding of the complaints process.</p> <p>There is both an electronic (VCare) and a hard copy complaint (feedback) register that includes written and verbal complaints, dates and actions taken. Five complaints were received in 2020 and nil in 2021 (year to date). All five complaints were reviewed. They were managed in an appropriate and timely manner as determined by the Health and Disability Commissioner and were signed off as resolved. The complaints process is linked to the quality and risk management system. Staff are kept informed regarding complaints received.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Regular contact is maintained with family including if an incident or care/health issues arises. Evidence of families being kept informed is documented on the electronic database (sighted in fifteen adverse events reviewed in the progress notes on myRyman). All four family members interviewed (two psychogeriatric, two hospital) stated they were well-informed. Resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Interpreter services are available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.</p>

provide an environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Yvette Williams is a Ryman healthcare village located in Dunedin. The care centre provides rest home and hospital levels of care (geriatric and medical) for up to 60 residents (all dual-purpose), and psychogeriatric (PG) care for up to 30 residents. During the audit, there were 89 residents in the care centre (4 rest home, 56 hospital and 29 psychogeriatric). There are also 32 serviced apartments certified to provide rest home level care with one rest home level resident occupying a serviced apartment at the time of the audit. One resident (hospital) was on respite. The remaining residents were either on the aged residential care contract (ARC) or aged residential hospital specialised services contract (ARHSS).</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2020 are documented with evidence of regular reviews. The village manager is currently working on development of the 2021 goals for the facility.</p> <p>The village manager has been employed by Ryman for over eight years. She attends over eight hours per annum of professional development activities related to managing an aged care facility. The village manager is supported by a full-time clinical manager/RN, a regional operations manager and three unit coordinators (one rest home/hospital/RN; one psychogeriatric/RN and one serviced apartment/EN).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager is responsible for operations during the temporary absence of the village manager. The unit coordinators/RNs are responsible for clinical operations during the temporary absence of the clinical manager.</p>
Standard 1.2.3:	FA	Yvette Williams has a well-established quality and risk management system that is directed by head office (Ryman

<p><b>Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>Christchurch). Quality and risk performance are reported across the facility meetings and to the organisation's management team. Discussions with the management team (one village manager and three unit coordinators [one hospital/rest home/RN; one psychogeriatric [PG]/RN; one serviced apartment/EN) and sixteen staff (six caregivers [three hospital, two PG, one serviced apartment], five RNs [two PG, three hospital], one enrolled nurse (EN) (PG), one health and safety officer/caregiver, one maintenance, two activities and lifestyle coordinators) and review of management and full facility meeting minutes reflect their involvement in quality and risk management activities.</p> <p>Family meetings are scheduled six-monthly and resident meetings are held every two months. These meetings occurred with lesser frequency in 2020 due to Covid-19. Minutes are maintained. Annual resident and relative surveys are completed. Survey results for 2020 indicated the residents and families are satisfied with the services received, although results are slightly lower when compared to 2019 (Note: the sample size reflected only 13 responses; 33%). Where opportunities for improvements are identified (eg, food, activities, grounds/buildings), quality improvement plans are completed with evidence to confirm that suggestions and concerns are addressed.</p> <p>The service has policies, 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 as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and service delivery. There are clear guidelines and templates for reporting. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Corrective actions are implemented and signed off where internal audit results reflect less than 95% compliance. Quality improvement projects (QIPs) are implemented where opportunities for improvement are identified with several examples provided. QIPs are signed off by the village manager when completed.</p> <p>Health and safety policies are implemented. A health and safety officer/caregiver is appointed who has completed external stage three health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. The hazard register indicates that identified hazards are regularly reviewed. New hazards are identified. Health and safety is a regular agenda item in the full facility meetings. External contractors are orientated to health and safety processes.</p> <p>Resident falls are monitored monthly with strategies implemented to reduce the number of falls (eg, falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments with follow-up by a physiotherapy assistant; routine checks of all residents specific to each resident's needs (intentional rounding); the use of sensor mats; and increased staff awareness of residents who are at risk of falling). Lounge carers monitor residents in the lounges during the PM shift when</p>
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		activities staff are not available.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring 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.</p> <p>Fifteen incident/accident reports (assessments) reviewed (five episodes challenging behaviours, two witnessed falls, eight unwitnessed falls) identified that all are fully completed and include follow-up by a registered nurse. Neurological observations are completed as per protocol for any suspected injury to the head including unwitnessed falls. The clinical manager is involved in the adverse event process, with links to the applicable meetings (eg, team Ryman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. Examples were provided of five section 31 reports that had been completed since the previous audit around pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files of staff employed since the previous certification audit (December 2020) were selected for review (four caregivers, two RNs, one enrolled nurse/EN, one gardener). Documents sighted included evidence of the employment process including interviewing, police vetting and reference checks. Also sighted in the staff files were signed employment contracts, job descriptions, completed orientation programmes and annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are also retained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. In-services and staff meetings are offered at different dates/times to encourage staff to attend.</p> <p>Fifty-one caregivers work in the special care (psychogeriatric) unit. Forty-five caregivers have completed an NZQA approved dementia/psychogeriatric qualification. The remaining six have been employed to work in the unit for less than 18-months and are enrolled to complete their dementia qualification.</p> <p>RNs are supported to maintain their professional competency. Eleven of twenty-three RNs have completed their</p>

		<p>interRAI training. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Registered nurses also attend training through the Ryman journal club.</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>In addition to the village manager and clinical manager/RN who both work full-time (Monday-Friday), there are three unit coordinators (UCs). One UC/RN is responsible for the hospital/rest home residents, one UC/RN is responsible for the psychogeriatric residents and one UC/EN is responsible for the serviced apartment residents.</p> <p>The PG unit (29 residents) is staffed with an RN and an EN seven days a week. This is in addition to the UC. On the two days that the UC is not available, the clinical manager (CM) or the hospital UC take responsibility. Of the caregivers on morning shift, there are four long-shifts and two short-shifts. On the afternoon shift there are two long-shifts, three short-shifts, and an additional lounge caregiver. The lounge caregiver works from 1400 – 2000. Two caregivers cover the night shift. There is one RN rostered on the PM shift and one RN on the night shift.</p> <p>The hospital/rest home (56 hospital and 4 rest home) is divided into three wings with 20 beds in each wing (Tyne wing = 18 hospital and 2 rest home; St John wing = 19 hospital and 1 rest home; and Highgate wing = 19 hospital and 1 rest home). One staff RN is assigned to each wing on the AM shift. Two staff RNs are rostered during the PM shift and one staff RN is rostered on the night shift. Caregiver staffing is determined at a ratio of one caregiver to five residents on the AM shift with an additional fluid assistant. The PM shift is staffed with eight caregivers (three long and five short-shifts with the long-shift caregivers rostered to a wing each). A fluids assistant and lounge carer assist during the PM shift. The night shift is staffed with one RN and three caregivers.</p> <p>The 32 serviced apartments had only 1 rest home level resident. In addition to a UC/EN responsible for the serviced apartments five days a week, a senior caregiver covers the remaining two days of the week. An additional caregiver staff works a short shift on the AM shift. The PM shift is staffed with one caregiver until 2100. After 2100, a caregiver in the rest home/hospital is assigned to answer any call bells in the serviced apartments. Caregivers and RNs carry cell phones that act as a pager system for communication purposes. Cell phones are linked to the call bell system.</p> <p>Activities are provided seven days a week for all residents in the care centre. A registered physiotherapist is available three days a week totalling twelve hours and a physiotherapy assistant is rostered for four hours, five days a week (Monday-Friday). There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Caregivers interviewed stated that overall the staffing levels are satisfactory and that the RN/EN staff provide good support. Residents and family members interviewed reported there are</p>

		adequate staff numbers.
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Yvette Williams utilises an electronic medication management system. Twelve electronic medication profiles were sampled (four hospital, four rest home including the resident from the serviced apartment, and four psychogeriatric level of care). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of 'as required' medication administered was documented in the electronic prescription.</p> <p>There were no residents self-administering on the day of audit. There are two medication rooms on site, one for each level of care and all have secured keypad access. The serviced apartment drugs are stored in a locked cupboard. Medication fridges had weekly temperature checks recorded and were within normal ranges. Medication room temperatures have been recorded and are within expected ranges. Air conditioners have been installed to ensure constant temperatures. Registered nurses, enrolled nurses and senior caregivers, who have passed their medication competency, administer medications. Medication competencies are updated annually and include syringe drivers, subcutaneous fluids, blood sugars and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Standing orders are not used.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking is prepared and cooked on site. There are three head cooks supported by four kitchenhands and two cook assistants. All staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with the company chef and the dietitian at organisational level. A current food control plan is in place expiring 9 May 2021. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Cultural, religious and food allergies are accommodated. Special diets such as pureed/soft, diabetic desserts, vegetarian and gluten free are provided.</p> <p>Project "delicious" is in place. Menu choices are decided by residents (or primary care staff if the resident is not able) and offer a choice of three main dishes for the midday meal and two choices for the evening meal including a vegetarian option. Diabetic desserts and gluten free diets are accommodated. Meals are delivered in hot boxes to each unit satellite kitchen and plated by caregivers. Feedback on the service is received from daily resident contact, resident meetings, surveys and audits. A quality improvement plan has been initiated following the resident survey.</p>

		Residents and relatives interviewed were overall complimentary of the menu and baking provided. There are nutritional snacks available in the psychogeriatric unit 24 hours a day.
<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>When a resident's condition alters, the registered nurse initiates a nursing review and if required, GP, nurse specialist consultation. The electronic progress note evidenced family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Residents interviewed reported their needs were being met. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in two treatment rooms. Wound management policies and procedures are in place. There were three current pressure injuries (one deep tissue injury, one unstageable and one superficial stage 2 pressure injury) in the psychogeriatric unit. Incident reports and section 31 notifications have been completed. There was one non-facility acquired stage 4 pressure injury in the hospital unit. A section 31 notification has been sent (sighted). Incident reports have been fully completed and next of kin have been notified. Pressure relieving equipment was sighted for all of these residents. The wound care specialist has been involved with the long-standing pressure injuries. There were a further seven superficial wounds in the psychogeriatric unit. Eight wounds are active in the hospital unit (all superficial). All wounds in both areas have corresponding wound assessments, wound management plan and evaluations. Long-term care plans contain detailed pressure prevention strategies. Monitoring charts were completed in the myRyman system. All nurses complete a wound care competency. Staff interviewed reported there were adequate pressure prevention resources available.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences.</p> <p>There is a suite of monitoring forms available on the myRyman system which include weight, vital signs, behaviour monitoring and assessment, pain, neurological observations and blood glucose monitoring. Progress notes documented changes in health status 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</p>	FA	<p>The team of six activities and lifestyle coordinators organise and implement the Engage activities programme, across the hospital unit, psychogeriatric unit and serviced apartments seven days a week. Activities staff attend on site and organisational in-services relevant to their roles. All activities staff hold current first aid certificates.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>through the resident meetings and satisfaction surveys.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, themes events and celebrations, indoor bowls, sensory activities, weekly van outings, and baking in the kitchenettes.</p> <p>The rest home resident in the serviced apartments can attend the serviced apartment programme or rest home programme but prefers to listen to talking books. One-on-one time is spent with residents who are unable to participate or choose not to be involved in the activity programme. Community involvement includes entertainers, speakers and church services.</p> <p>The psychogeriatric unit has access to an outdoor garden setting, a 'sensory room' (including fairy lights, dimmed lighting, and calm music. RNs interviewed stated this room is often used to calm residents when agitated. Residents in the psychogeriatric care unit are taken for daily walks (observed) around the indoor gardens. The lounge carers assist with activities and one-on-one time with residents.</p> <p>Celebrations and special days are celebrated in the facility and the hospital and psychogeriatric units were decorated for Chinese new-year at the time of the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plans for the resident files reviewed were evaluated by the registered nurse within three weeks of admission. Evaluations identified if the resident/relative desired goals had been met or unmet. All changes in health status were documented and followed up. The multidisciplinary review involves the RN, activities staff resident/family and unit coordinator. The resident files reviewed reflected evidence of family being involved in the planning of care and reviews and if unable to attend, they are notified of changes. There is at least a three-monthly review by the medical practitioner with the majority of the hospital level residents being seen monthly. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</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 building had a current building warrant of fitness that expired 14 October 2020. A building systems status report (BSSR) has been issued in place of an updated building warrant of fitness following missed inspections over the Covid-19 lockdown (confirmed in an email sighted from Compliance Consultants (22 October 2020) with the additional statement that all of their buildings and systems are still considered compliant by councils). The facility has been instructed to not display this certificate in a visible location. Evidence was sighted of six-monthly fire evacuation drills.</p> <p>The facility is divided into three floors with the special care unit (PG) on level one (ground), hospital on level two and serviced apartments on level three. There is a central reception area, a large communal lounge and dining room for apartment residents. Each unit in the care centre has a lounge and dining area with the hospital divided into two smaller areas, each with kitchen/server, dining and lounge areas. The PG unit has a secure garden area which is</p>

		<p>easily accessible and provides seating and shade. Residents were observed to access the outdoor areas safely.</p> <p>The maintenance person attends to any maintenance requests or call in contractors as required. There is a 12-monthly planned maintenance schedule in place. Electrical equipment has been tested and tagged. Hot water temperatures in resident areas are monitored three-monthly and are within acceptable ranges. The hoist and scales are checked annually.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Individual infection reports are electronically recorded and a checklist for care is generated. The interim infection control officer (interviewed) collects monthly data and attends the two-monthly health and safety meetings. Staff are informed through facility meetings held at the facility. The infection prevention and control programme is linked with the TeamRyman programme. The infection control officer uses 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 to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>In October 2020, there was a scabies outbreak. The outbreak was well managed. Staff were updated at each change of shift. The service informed the public health team and the GP, the outbreak was not notifiable. There have been no other outbreaks. The staff at Yvette Williams continue to consistently remain below benchmark in the hospital and psychogeriatric units for urinary tract infections with no urinary tract infections recorded for 9 out of 16 months from April 2019 to January 2021. There have been no eye, ear, nose and throat infections for 10 out of 16 months for the same period.</p> <p>Covid-19 was managed well. Staff interviewed described online training and one-on-one competencies for donning and doffing personal protective equipment. Policies, procedures and the pandemic plan have been updated. Changes have been discussed at meetings and through ongoing education sessions. Adequate personal protective equipment was sighted during the audit. Outbreak kits are easily accessible in nurses' stations throughout the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are 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. The restraint coordinator is the unit coordinator for PG residents. During the audit there were nine residents (six PG unit and three hospital) using a restraint and no residents using an enabler. The types of restraints used include bedrails (four) and chair harnesses (six). Note: some residents use more than one type of restraint.</p> <p>Staff training is provided at orientation and annually thereafter around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

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# Specific results for criterion where corrective actions are required

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

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

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

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

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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.

No data to display
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End of the report.