

Bob Owens Retirement Village Limited - Bob Owens Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bob Owens Retirement Village Limited
Premises audited:	Bob Owens 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: 3 February 2021 End date: 4 February 2021
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:	118



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bob Owens is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia, and hospital levels of care for up to 150 residents. There were 118 residents at the time of the audit.

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

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

There were no areas for improvement identified at the previous certification audit.

This surveillance audit identified an improvement required to administration of medication.

An area of continuous improvement was awarded to the restraint minimisation programme.

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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Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented, and a complaint register maintained. Complaints were described as being able to be responded to in a timely manner.

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 and coordinated to meet the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations with a role for an assistant manager currently being advertised. Village goals are documented for the service with evidence of regular reviews. Key components of the quality and risk management programme are documented and include management of complaints, an internal audit schedule, completion of satisfaction surveys, analysis of incidents and accidents, and an implemented health and safety programme.

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

Registered nursing cover is provided 24 hours a day, 7 days a week. Staff in the dementia unit have completed relevant training around dementia. Rosters and interviews with staff, residents and family indicated that there are sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs.

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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The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

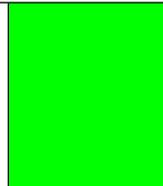
The activity programme is developed to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital, and dementia care residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts were reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being provided 24 hours per day.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The building has a Building Systems Status Report issued in lieu of the BWOFF certificate as one of the specified systems could not be tested or checked during the Covid-19 lockdowns. All external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place.

Restraint minimisation and safe practice

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



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

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents assessed as requiring the use of restraint. One resident was using an enabler for safety. Staff receive ongoing education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme includes policies, standards, and procedures to guide staff. 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 (unit coordinator/RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking with other Ryman facilities. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	14	0	1	0	0	0
Criteria	1	39	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). There was one complaint lodged in 2019 that was resolved in a timely manner. The village manager reported that the family were satisfied with the outcome. There were no complaints lodged in 2020 or in 2021 to date. The village manager reported that they make every effort to meet face-to-face with complainants. It was noted that residents knew the village and clinical managers by name and vice versa and there was a steady stream of residents seen to be having conversations in general with the managers.</p> <p>The complaints process is linked to the quality and risk management system. There is evidence of complaints received being discussed in staff and management meetings.</p> <p>Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction.</p> <p>There have not been any complaints from external providers since the last audit.</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>The following staff were interviewed; 10 caregivers, three-unit coordinators, six registered nurses, cook, physiotherapist, three activity and lifestyle coordinators (all of whom are diversional therapists), maintenance staff along with the clinical manager and village manager. Nine residents were interviewed (seven in the rest home and two in the hospital) and seven family members were interviewed (one in the rest home, four in the hospital and two in the dementia unit).</p> <p>Open disclosure occurs between staff, residents, and relatives. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. This was evidenced in all 21 adverse events reviewed electronically on VCare. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. This has not been required to date. There has been frequent communication both with residents and relatives during the Covid-19 pandemic.</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>Bob Owens is a Ryman Healthcare retirement village. The care centre is modern and spacious. The facility is built across three floors and is designed around a large atrium and courtyards. It provides rest home, hospital and dementia levels care for up to 150 residents.</p> <p>This includes 40 rest home level beds on the ground floor, 40 hospital level beds on the first floor, 40 dementia level beds across two wings on the second floor and 30 serviced apartments that are certified to provide rest home level care. All 80 rest home and hospital level beds in the care centre are certified as dual purpose. Occupancy during the audit was 118 (42 rest home level residents [including 3 in the serviced departments]; 39 hospital level residents and 37 dementia level residents).</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. Annual organisational objectives are defined with evidence of monthly reviews and quarterly reporting to Ryman Christchurch on progress towards meeting these objectives. Evidence in staff and management meeting minutes and six-monthly reviews against the plan reflects discussions around the annual objectives.</p> <p>The village manager has been in the role for six years and has a Bachelor of Social Science (human resource). The service is currently advertising for an assistant to the manager. A clinical manager (registered nurse) provides clinical oversight and leadership. The clinical manager has been in the role for six years and has extensive experience in aged care and emergency care nursing in previous years. The management team is supported by a team at head office. The management team have maintained at least eight hours each of professional development activities related to managing an aged care facility.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Bob Owens has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers and staff and review of management and staff meeting minutes reflected their involvement in quality and risk management activities.</p> <p>Resident meetings are held two-monthly for the hospital, rest home and dementia units and relative meetings are held six-monthly noting that some were delayed throughout lockdown periods as a result of the pandemic. The village manager and/or clinical manager attend these meetings and minutes are maintained.</p> <p>Resident and relative surveys are completed annually. The net promoter score for the hospital is high at 4.63 with the rest home net promoter score at 4.09. Both were down slightly from the previous year. The net promoter score for the relative survey completed in August 2020 was at 4.42 with all areas rated higher in satisfaction than the previous year. The village was rated as number two of 32 villages as a result of the relative survey results.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems and policies are developed, implemented, and regularly reviewed, meeting sector standards and contractual requirements. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored through the monthly Health and Safety Committee meetings. A health and safety officer is appointed. 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 staff. Quality improvements are implemented where indicated. Ryman has achieved tertiary level ACC Workplace Safety Management Practice. A review of the hazard register and the maintenance register indicates that there is resolution of issues identified. All contractors are inducted to health and safety processes by maintenance staff. All new staff are inducted and orientated to the facility and are advised of the health and safety programme. There is also annual health and safety in-service training with additional training for staff around Covid-19 including training and competencies around personal protective equipment and cleaning. Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment.</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 on VCare for each incident/accident with immediate action noted and any follow-up action required. Pressure injuries are documented on a wound report in VCare.</p> <p>A review of 21 incident reports (eg, witnessed and unwitnessed falls, pressure injuries and challenging behaviour) identified that all are fully completed and include follow-up by a registered nurse. The unit managers are involved in the adverse event process. Regular management, clinical and staff meetings and informal meetings during the week provide an opportunity to review any incidents as they occur. Neurological observations are completed as per policy if there is a suspected injury to the head (eg, unwitnessed falls).</p> <p>The village manager and clinical manager interviewed were able to identify situations that would be reported to statutory authorities. Evidence of notification to public health authorities was evidenced for two suspected deep tissue wounds and one for a stage three pressure injury.</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>	<p>FA</p>	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation, and staff training and development. Each staff HR file out of nine staff files reviewed (two caregivers, two registered nurses, one clinical manager/RN, one unit manager, one activities coordinator, one laundry assistant, one senior lead chef) included a signed contract, job description relevant to the role the staff member is in, police check, induction paperwork, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of nursing practising certificates is maintained within the facility. Practising certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. A general orientation programme that is attended by all staff covers (but is not limited to): Ryman's commitment to quality; code of conduct; staff obligations; health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and 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. Training is offered multiple times/days to ensure that staff are able to attend. Staff also complete annual competency questionnaires. Registered nurses are supported to maintain their professional competency. Six of fourteen registered nurses</p>

		<p>including the clinical manager and three-unit coordinators, have completed their interRAI training. RNs and ENs attend journal club. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including (but not limited to) medication competencies and insulin competencies.</p> <p>Twenty-five caregivers work in the dementia unit. Of the 25, 22 have completed the required dementia standards, and three are currently completing the training with final documentation being signed off. There is a casual caregiver who has also completed the 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, assistant to the manager (when appointed) and clinical/RN work Monday – Friday and are available on call if required.</p> <p>The hospital wing (occupancy 39 hospital residents) is staffed with a unit coordinator/RN five days a week. Two staff RNs cover the AM shift and the PM shift, and one RN covers the night shift. The AM shift is staffed with four long shift, four short shift caregivers, and a fluid assistant; the PM shift is staffed with two long shift and five short shift caregivers and the night shift is staffed with three long shift caregivers.</p> <p>The dementia unit is split into two separate units with 37 residents residing in the Meadowbank and Carmichael units. A designated unit coordinator/RN works on the AM shift five days a week. There are two RNs on the AM shift, one on the afternoon and one on the night shift. Each AM and PM shift are staffed with one long and one short shift caregiver on each unit with three caregivers overnight. Two activity coordinators in the morning support residents and a lounge caregiver are rostered in the afternoon on a short shift.</p> <p>The rest home wing (39 rest home level residents) is staffed with one unit coordinator/RN on five days a week with a registered nurse rostered on the other two days when the unit coordinator is not available. The AM shift is staffed with two short and two long shift caregivers; the PM shift is staffed with two short shift and two long shift caregivers and the night shift is staffed with two long shift caregivers.</p> <p>Service apartments (three rest home level residents) are staffed with one-unit coordinator/EN five days a week. A senior caregiver is rostered on the two days that the unit coordinator is not available. The AM is staffed with four caregivers (two long and two short shift); two caregivers in the PM, (one long and one short shift); and overnight, the apartments are covered by the caregivers and registered nurse in the rest home via a pager system.</p> <p>Any staff on leave are covered by casual staff and bureau is not used. There is a low turnover rate. The staff survey completed in April 2020 showed a high level of satisfaction with the service rated as number two of 35 villages. The promoters of the service as evidenced in the service showed a rating of 37% in October 2016 with a steady increase over the years to 85% in 2020. Staff on the floor on the days of the audit, were visible and were</p>

		<p>attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised medication blister packs for regular and 'as needed' (PRN) medications. Medications are managed appropriately in line with required guidelines and legislation. Medication fridge temperature monitoring is undertaken. Medication reconciliation is completed on delivery. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role regarding medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit, however policies and procedures are in place to appropriately assess residents as competent to self-administer should the need arise.</p> <p>Fourteen medication charts were initially sampled. Two of the fourteen did not have documented instructions related to the resident requiring crushed medications (or opened capsules). The sample size was increased by three and these three (two rest home, one dementia) were also found to lack the required documented indications/instructions regarding crushed medications. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</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 meals at Bob Owens are all prepared and cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The senior lead chef (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. There is a food control plan expiring 22 January 2022.</p> <p>The residents interviewed were very satisfied with recent changes in the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident</p>

		surveys.
<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>Family interviewed expressed satisfaction with the level of care provided. The general practitioner also expressed satisfaction with the care received by residents and the service in general. RNs and caregivers report progress against the care plan at least daily. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Communication with family is documented in progress notes and on the family communication sheet.</p> <p>Care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (eg, resident turns, fluids given). Monitoring charts are well utilised. Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Continence products are available and resident records include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the registered nurse. Care plans documented the continence care and support required for each resident and continence products were available according to the continence plan.</p> <p>Monthly weighs have been completed in all long-term files sampled. Referral to dietitian occurs as required, as confirmed in sampled files.</p> <p>Wound assessment, wound management plans and monitoring were in place for all identified wounds. This included 33 wounds in total, comprised of 13 minor skin tears, three abrasions, four lesions, four chronic ulcers, two pressure injuries and seven classified as 'other' (dermatitis etc). There were two pressure injuries at the time of audit which show appropriate management, review, and documentation. All wounds have been reviewed in appropriate timeframes and specialised wound management advice through the DHB wound care specialist and Ryman wound champion was in evidence where required. Dressing supplies are available, and the treatment rooms are stocked for use. Staff receive regular education on wound management.</p> <p>InterRAI assessments tools are used for any change in health condition and to develop the ongoing care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record. Evidence was sighted for speech language therapist, physiotherapist, dietitian, hospice, podiatrist, mental health services and wound care specialist (DHB virtual wound clinic).</p> <p>The myRyman programme identifies interventions that cover a comprehensive set of goals including managing</p>

		<p>medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as wound or recent fall. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed.</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>There are four activity and lifestyle coordinators who provide a separate Monday to Friday activity programme for the rest home, and seven-day programme for hospital and dementia care units. There are separate activities available for the serviced apartment residents. A company diversional therapist (DT) oversees the activity programmes. The activity coordinators attend Ryman workshops and on-site in-services. The three activities coordinators interviewed had completed their DT qualifications. All hold current first aid certificates.</p> <p>The programme is planned monthly and includes Ryman minimum requirements for the "Engage" activities programme. Activities programmes are displayed on noticeboards around the facility and a monthly calendar is delivered to each individual resident. There is a core programme, which includes the triple A (Active, Ageless, Awareness) exercise programme. Activities are delivered to meet the cognitive, physical, intellectual, and emotional needs of the residents. One-on-one time is spent with residents who are unable to actively participate in the activities.</p> <p>A variety of individual and small group activities were observed occurring in the rest home, hospital, and dementia care units at various times throughout the days of audit. Residents in serviced apartments can choose to attend the serviced apartment or rest home/hospital activities. Entertainment and outings are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed.</p> <p>An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment, and outings. Resident meetings are held two-monthly and family meetings six-monthly. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents interviewed spoke positively about the activity programme provided.</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 evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Six long-term care files sampled of permanent residents contained written evaluations completed six-monthly. The other one file was not yet due for evaluation. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</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 four floors (including serviced apartments). All care beds (dementia excluded) are dual purpose; however the service currently runs as floor one rest home, floor two hospital and floor three dementia. Floor three consists of 2 x 20 bedded dementia units. Floor four is solely serviced apartments (three of which are certified for rest home level care). The other certified serviced apartments are on floor one, with independent serviced apartments being spread across all floors. 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 Building Systems Status Report that gets issued in lieu of the BWOFF certificate if one or more of the specified systems could not be tested or checked during the Covid-19 lockdowns. The report is compiled by the IQP contractors who could not issue their Form12a but confirm that the specified system is performing as intended. This was sighted on the day of audit and sufficiently covers the warrant that was due during Covid lockdown as the required monthly building maintenance checks were being completed (also sighted).</p> <p>The facility employs a full-time maintenance officer, 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. This is next due September 2021. 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. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The dementia care units each include an open plan dining/lounge area. There is free and safe access to the outdoor deck areas with raised gardens, seating, and shade.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	<p>FA</p>	<p>The surveillance programme is organised and promoted via the Ryman calendar. Effective monitoring is the responsibility of the infection prevention and control officer who is a unit coordinator (RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the clinical meeting, weekly management meeting, infection prevention and control (IPC) meetings and full staff meetings.</p> <p>Six-monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Ryman Bob Owens include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and are analysed at site level</p>

<p>have been specified in the infection control programme.</p>		<p>using power BI (A business analysis tool which is used to run reports based on a company's data).</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>CI</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There have been no residents using restraints since 10 December 2017 and has resulted in a rating of continuous improvement (a rating also awarded at the previous certification audit). One hospital level resident has voluntarily requested a lap belt on their wheelchair with this identified as an enabler. The resident record evidenced documentation completed as per policy with the use of an enabler monitored two-hourly when on.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	<p>The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. Not all medication charts had correct instructions regarding the administration of crushed medications. There is a corrective action plan in place to address the correct charting of medications (sighted on day of audit). A staff meeting, and education sessions have been scheduled as has a meeting with the general practitioner.</p>	<p>Five of seventeen medication charts reviewed did not contain the required documented indications/instructions regarding crushed medications.</p>	<p>Ensure all resident medication charts are fully completed with indications/instructions regarding crushed medications.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence</p>	CI	<p>The restraint coordinator is the unit coordinator/RN for the hospital level residents. They have been in the role for over six years.</p> <p>The use of enablers requires voluntary consent by the resident every six months. Appropriate assessment procedures are implemented. One file was reviewed of a hospital level resident who has voluntarily requested that a lap belt is put on while in a wheelchair. Evidence of an appropriate assessment process and six-monthly signatures by the resident consenting to the enabler were sighted. The resident and family</p>	<p>The facility has been restraint free since 10 December 2017. Staff attend annual education and complete competencies annually around restraint minimisation. Care staff interviewed were able to identify a range of strategies used that meant that restraint was not required. One resident record showed that care staff had assessed needs of the resident and as a result had used strategies such as toileting two hourly, behavioural management, and encouraging the resident to take naps during the afternoon that prevented the potential use of restraint. This resident had reduced the number of incidents from 11 in December to three in January. Strategies described and implemented for other residents included family education, successful implementation of de-escalation techniques, and ensuring appropriate equipment is utilised where needed (eg, low beds, perimeter mattresses, intentional rounding, regular toileting, landing and sensor mats). Lounge carers (dementia and hospital) monitor residents closely for any signs of restlessness. Activities to engage residents are used. The service has continued to monitor the restraint minimisation programme through six monthly meetings.</p>

and safety.		interviewed confirmed the use of the enabler and confirmed that they wanted to have this as they accessed outdoor areas regularly and felt safer with the device. The facility is restraint-free and has resulted in a rating of continuous improvement.	
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End of the report.