

# Logan Campbell Retirement Village - Logan Campbell Retirement Village

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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>	Logan Campbell Retirement Village
<b>Premises audited:</b>	Logan Campbell Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 13 April 2021    End date: 14 April 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>	115



# 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
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

Ryman Logan Campbell is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital (geriatric and medical) level care for up to 122 residents in the care centre and up to 30 residents at rest home level of care in the serviced apartments. There were 115 residents at the time of the audit.

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 has been in the role three years and has eleven years' experience working within the aged care industry. She is supported by an experienced resident services manager and an experienced clinical manager who has been in the role one year.

The residents and relatives interviewed spoke positively about the care and support provided.

This surveillance audit did not identify any areas for improvement.

## 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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The management team operate an open-door policy and were visible within the units interacting with residents and families. Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in making care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. There are regular resident meetings and there are relative meetings twice yearly. Residents and relatives have the opportunity to feedback through meetings and annual surveys.

There is an established system for the management of complaints, which meets timeframes established by HDC. There are code of rights posters, advocacy pamphlets and complaints forms available in each unit. The welcome/information pack includes information about the Code.

## 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, resident services 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 in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. A site induction and 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 and on call 24/7. 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 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.

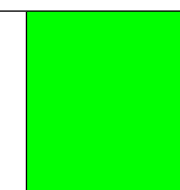
The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if 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 reviewed met all prescribing requirements and were reviewed at least three-monthly.

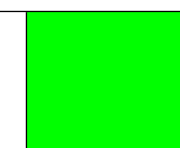
Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being provided 24 hours per day.

## 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.
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The building has a current warrant of fitness. There is a reactive and planned maintenance schedule in place. There are spacious communal lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities.

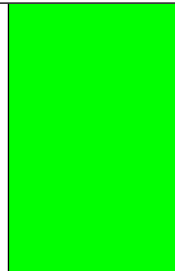
## Restraint minimisation and safe practice

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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The service continues to remain restraint free. There is a restraint approval group that meet six-monthly to review restraint minimisation strategies. Staff have received education in de-escalation and challenging behaviours last October 2020.

## Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control officer/clinical manager 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. There is a Ryman Covid pandemic plan in place and sufficient supplies of personal protective equipment available.



## 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	16	0	0	0	0	0
<b>Criteria</b>	0	41	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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Code of Rights posters, advocacy pamphlets and complaints forms are available in the main entrance. Information about complaints is provided on admission. Interviews with six residents (two rest home and four hospital level of care) 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 for each unit 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 have been two complaints in 2020 and two complaints for 2021 to date in the rest home, two complaints in 2020 and two complaints for 2021 in the hospital. There has been one DHB complaint in March 2020 and one complaint for 2021 to date in the dementia care unit. The DHB complaint related to resident care for a suspected fracture, was investigated and a corrective action plan implemented to the satisfaction of the DHB and complainant. The DHB has closed out the complaint October 2020. The corrective action plan included staff education on management of falls (including hoist use from the floor) and falls prevention, moving and handling sessions, post-falls assessments, compulsory pain assessments following falls and falls case-by-case analysis. Corrective actions identified continue to be implemented.</p> <p>Staff are kept informed of complaints received that are related to their role and responsibilities.</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>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Thirteen incident forms reviewed identified the relative/EPOA had been notified. Three relatives/enduring power of attorney (EPOA) of dementia care residents confirmed they had been notified following a change of health status of the resident. Relative meetings are held twice a year. There is evidence of relative involvement in six-monthly MDT (multidisciplinary) reviews. Residents and relatives are informed of survey results. There are resident meetings held in the rest home (Tamaki) and hospital (Cornwall) units. Speakers are invited to attend, such as, field officers for melanoma and macular degeneration. Families are invited to attend the resident meetings.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Logan Campbell Retirement Village is a Ryman Healthcare facility located in Greenlane. This 122-bed care centre is located on three levels. There are also 82 serviced apartments with 30 serviced apartment beds certified for rest home level of care. All beds in the hospital and rest home are certified as dual purpose. There was a total of 115 residents on the day of audit.</p> <p>There were 43 hospital level residents and 44 rest home level residents (including two residents at rest home level of care in the serviced apartments) and 28 residents in the two dementia wings. There was one rest home resident on an ACC fully funded contract. All other residents were under the aged residential care contract (ARCC).</p> <p>Ryman Healthcare has an organisational total strategic business plan and quality management plan. Logan Campbell has village objectives for 2021 including clinical performance, meeting cultural and spiritual needs, provision of food services and human resource management. Quality objectives and quality initiatives are reviewed regularly to reflect progress to date. Goals achieved in 2020 include strengthening relationships with the mental health services for the older person and there are now four weekly meetings with the mental health services and an occupational therapist. There has been a greater focus on palliative care with the introduction of the Te Ara Whakapiri pathway.</p> <p>The village manager (non-clinical) at Logan Campbell has leadership experience in the service industry and has been in the role three years. She is supported by a resident services manager (non-clinical) and an experienced clinical manager who has been in the role for one year. A notification to HealthCERT for change of clinical manager dated June 2020 was sighted. The management team is supported by a regional manager and Ryman Christchurch (head office).</p> <p>The village manager has completed at least hours of training related to the role including incident/accident investigation/management, cyber security awareness, dementia friend certificate and privacy training. The clinical manager completed orientation following her appointment and has completed LEAP Ryman training level 1.</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>Ryman Logan Campbell is implementing a quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across facility meetings (management, full facility, clinical RN and EN, caregiver, health and safety, infection control and restraint) and also to the organisation's management team. Discussions with the managers and staff and review of management and staff meeting minutes demonstrated their involvement in quality and risk management activities.</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 full facility (monthly) meeting minutes.</p> <p>Resident and relative surveys are scheduled to be completed annually. The October 2020 survey demonstrated that residents and relatives were very satisfied with the care and services provided. The two lowest rating services - activities and food services have quality improvement plans in place (even though they were above the average score).</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. The facility has implemented processes to collect, analyse and evaluate data including accidents/incidents, infections, wounds/pressure injuries and medication errors. All data and benchmarking is discussed and documented at the facility meetings. Corrective actions are signed off when implemented.</p> <p>Internal audits have been completed as scheduled and corrective actions developed where results are less than expected. Corrective actions have been signed off when completed. Audit outcomes are discussed and documented at facility meetings.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee who are representative of all areas of service. Health and safety representative (interviewed) the Resident Services Manager has completed level 1 and 2 of external health and safety courses. A focus group (representative of staff from all areas) meets quarterly to discuss any issues/concerns with their areas. 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. Staff report hazards and any near misses which are reviewed by the health and safety committee. Staff have access to meeting minutes, health and safety updates and videos. The hazard register (general and specific) was reviewed in June 2020.</p> <p>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. Contractors receive health and safety inductions.</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Falls have showed a reduction for rest home level residents with an average of 1.78 against the group</p>
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		average of 6.1/1000 bed days.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted, RN assessment and any follow-up action required.</p> <p>A review of 13 incident/accident reports for the month of March and April 2021 (witnessed and unwitnessed falls, skin tears, challenging behaviours) identified that all were fully completed and include follow-up by a registered nurse. Neurological observations had been completed for unwitnessed falls where a resident could not confirm if they hit their head or not. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities. There have been three Section 31 notifications since the last audit. There were two notifications for unstageable pressure injuries (September 2019 and April 2021) and one police involvement for resident aggressive behaviour March 2021.</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 human resources (HR) policies including recruitment, selection, orientation and staff training and development. All ten staff files reviewed (two caregivers, one unit coordinator, two registered nurses, one chef, one laundry, one diversional therapist, clinical manager and village manager) included a signed contract, job description, police check and orientation. All staff complete an induction programme followed by specific orientation relevant to their role. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming. Staff interviewed stated there was adequate time allocated to the orientation process.</p> <p>A register of registered nurse 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>There is an implemented annual in-service calendar that has been completed for 2020 and implemented for 2021. Annual comprehension surveys are completed. Staff complete competencies relevant to their role including hand hygiene, medications, moving and handling and first aid. Training is offered multiple times/days to ensure that staff are able to attend. External health professions are involved in providing in-service including the physiotherapist, wound care specialist and hospice.</p> <p>Registered nurses are supported to maintain their professional competency. Eleven of seventeen registered nurses, including the clinical manager have completed their interRAI training. RNs attend journal club meetings and DH study days as offered. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the</p>

		<p>care facility and on outings.</p> <p>There are 17 caregivers who work in the dementia units. Fourteen caregivers have completed the required dementia unit standards, one in progress and two are newly employed and have been at the service less than six months.</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. Rosters implement the staffing rationale. The village manager, resident services manager, and clinical services manager/RN work Monday – Friday. All beds in the rest home and hospital wings are certified for dual purpose.</p> <p>There are three-unit coordinators. The rest home coordinator/RN works Sunday to Thursday. The hospital unit coordinator works Tuesday to Saturday and the dementia care unit coordinator works Tuesday to Saturday. A senior RN covers each of the unit coordinators days off. There is a RN on all shifts in the hospital wing and a RN on the morning duty in the special care unit.</p> <p>The rest home (Tamaki) wing has 46 beds available including three double rooms. On the day of audit there were 42 rest home residents. The morning shift is staffed with two long shift (7 am – 3.30 pm) and two short shift (7 am – 1.30 pm) caregivers. The afternoon shift is staffed with two long (3 pm- 11 pm) and two short shift (4.30 pm-8.30 pm) caregivers and the night shift is staffed with two caregivers (11 pm – 7 am). One activities coordinator covers five days a week. There is a fluids assistant 9 am – 1 pm.</p> <p>The hospital (Cornwall) wing has 46 beds (includes three double rooms). There were 43 hospital residents. The morning shift is staffed with five long shift (7 am – 3.30 pm) and five short shift (7 am – 1.30 pm) caregivers. The afternoon shift is staffed with four long (3 pm-11 pm) and four short shift (4.30 pm-8.30 pm) caregivers and there is a lounge carer 4 pm-8 pm. The night shift is staffed with two caregivers (11 pm – 7 am). One activities coordinator covers seven days a week.</p> <p>There are two dementia units (A and B) both with 15 beds each. There are 14 residents in each unit. Each unit is staffed with one long and one short shift caregiver. There is an activity coordinator 9.30 am – 6 pm and a lounge carer 9.30 am – 3 pm. There are two caregivers on night shift.</p> <p>Serviced apartments (2 rest home level residents) are staffed with a foreign trained RN/coordinator (who has not completed the New Zealand nursing equivalency) and a senior caregiver covers the days off. The morning shift is staffed with one long and one short shift caregiver, and the afternoon is staffed with two short shift caregivers (4 pm-9 pm). After 9 pm, a designated caregiver in the rest home wing covers the serviced apartments. The call system in the serviced apartments is linked to the caregiver pagers.</p> <p>Staff interviewed stated that overall the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>

<p><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>	<p>FA</p>	<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 and room temperature monitoring is undertaken with evidence of all temperatures being within the required range. 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.</p> <p>There were five residents self-medicating on the day of audit, all of whom had been assessed as competent to self-administer by the RN and GP. The resident's rooms were visited and confirmation that the medications were stored securely obtained. Standing orders are not used.</p> <p>Fourteen medication files were reviewed (six rest home, four hospital and four dementia level of care) on the electronic medication management system and all met prescribing requirements. There was photographic identification and allergy status documented on each medication chart.</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>	<p>FA</p>	<p>The meals at Ryman Logan Campbell 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 which expires 9 May 2021. 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.</p> <p>The residents interviewed were very satisfied with the standard of 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 surveys.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Family interviewed expressed satisfaction with the level of care provided and the GP also expressed satisfaction with the care received by residents and the service in general. Registered nurses 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 (e.g., 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 log.</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, (e.g., 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>Contenance 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 twenty wounds in total, comprised of five minor skin tears, two lesions, seven chronic ulcers, three pressure injuries, one post-surgical wound and two classified as 'other' (dermatitis etc). There were three pressure injuries (all hospital level residents) at the time of audit which show appropriate management, review and documentation. There was one stage 1 and one stage 2 that were facility acquired and a stage 3 pressure injury that was community acquired. 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 medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as</p>
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		(but not limited to); 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>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are two activity and lifestyle coordinators (qualified diversional therapists) and two activities assistants 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. 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>	FA	<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. Seven long-term care files reviewed of permanent residents contained written evaluations completed six-monthly. 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 a code of compliance schedule that expires 25 November 2021. There is a full-time maintenance manager and village support maintenance person. A maintenance register is maintained for the village and requests signed off as completed. The maintenance manager is available on-call for urgent facility matters. There are essential contractors available 24/7. There is a planned maintenance plan that includes electrical testing and tagging and calibration of clinical equipment and testing of electrical beds and hoists. Hot water temperatures in resident areas are monitored three-monthly as part of the environmental audit and stable below 45 degrees Celsius.</p> <p>The communal lounges and hallways have wide corridors to promote safe mobility with the use of mobility aids. All rooms and communal areas allow for safe use of mobility equipment such as hoists and hospital lounge chairs. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>There is a gardening and grounds team who maintain external areas. The gardens provide paths, seating and shade. Each dementia unit has two secure external decks providing access to open air and small garden areas.</p> <p>Caregivers and registered nurses interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</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>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control coordinator (clinical manager) completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported and discussed at the two monthly infection prevention and control meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed. Infection control monthly data is benchmarked at head office.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, any areas for improvement and education needs within the facility.</p> <p>Ryman have set up their own Covid website with resources and information. There was a DHB Covid preparedness assessment of the service completed May 2020. Additional education around Covid isolation, alert levels and personal protective equipment was provided. Regular zoom sessions with the DHB and head office were held, and sufficient personal protective equipment was provided.</p> <p>There was a norovirus outbreak in the rest home in September 2019. In July 2020 there was a suspected influenza outbreak in the dementia care unit. There is evidence of notifications for both outbreaks to the public health unit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. The clinical manager is the designated restraint coordinator. Logan Campbell continues to be restraint-free and there were no residents using enablers.</p> <p>Staff training is provided around restraint minimisation and enablers, falls prevention, and management of challenging behaviours (last October 2020). Restraint minimisation audits are completed six-monthly.</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.