

Bert Sutcliffe Retirement Village Limited - Bert Sutcliffe Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bert Sutcliffe Retirement Village Limited
Premises audited:	Bert Sutcliffe 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: 4 August 2021 End date: 5 August 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:	116



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ryman Bert Sutcliffe provides rest home, hospital (geriatric and medical) and dementia level of care for up to 150 residents. There were 116 residents at the time of the audit.

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

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

Two areas of continuous improvements were identified in relation to the activities programme and restraint minimisation.

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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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are being implemented. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established and implemented Māori health plan in place. Individual care plans reflect the cultural needs of residents. Discussions with residents and relatives confirms that residents, and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an incident or has a change in their current health. Families and friends visit residents at times that suit them.

There is an established system implemented for the management of complaints that meets requirements set forth by HDC.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. An acting village manager, acting resident services manager and clinical manager are responsible for the day-to-day operations. They are supported by four-unit

coordinators, one for each level of service (rest home, hospital, dementia, serviced apartments). Goals are documented for the service with evidence of regular reviews.

Comprehensive quality and risk management programmes are implemented. Corrective actions are put in place and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided seven days a week, twenty-four hours a day. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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

Continuum of service delivery

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

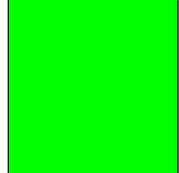
The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if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

Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet all prescribing requirements and are reviewed at least three-monthly.

Food services and 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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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. All rooms have ensuite. External areas are safe and well-maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There are spacious lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities. Resident rooms are spacious and allow for safe movement of staff and mobility equipment. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There was one resident with restraint and no residents with enablers during the audit. Staff have received 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control prevention and control leader (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control leader has attended internal and external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control leader uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information related to the Code is made available to residents and their families. Four managers (one acting village manager, one clinical manager, one acting resident services manager, one regional manager) and twenty-eight care staff (four unit coordinators (three registered nurses (RNs) and one enrolled nurse (EN), five registered nurses (RNs), ten caregivers (four hospital, two dementia, two serviced apartments, two rest home) who work during the AM and PM shifts, two laundry staff, three activities coordinators, one chef, one physiotherapist, one maintenance, one village support) interviewed understand the Code and its application to their job role and responsibilities. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident in all eleven resident files reviewed (three rest home- including one on an ACC and one respite contract, five hospital and three dementia residents). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents’ charts. All resident files reviewed</p>

information they need to make informed choices and give informed consent.		in the dementia unit had activated EPOAs.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Eleven complaints reviewed for 2021 (year to date) have been managed in a timely manner with nine of the eleven complaints documented as resolved. Timeframes are met as per Health and Disability Commissioner (HDC) guidelines. Evidence was sighted of complaints being discussed in the weekly management and monthly staff meetings.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Six relatives (three hospital, three dementia) and seven residents (four rest home with one in a serviced apartment, three hospital) stated they were provided with information on admission which includes the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The acting village manager reported having an open-door policy. The information pack is discussed with residents/relatives on

		admission. Relatives and residents are informed in writing of the scope of services and any liability for payment for items not included in the scope.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support the residents' privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed whilst assisting with care.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process with family involvement. Instructions are provided in the admission agreement regarding responsibilities of personal belongings. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement in assessment and care planning and visiting is encouraged. Links are established with Ngai Tai Ki Tamaki with evidence of annual contact. There were no residents who identified as Māori at the time of the audit although there was one family member of a resident who identified as Māori. She confirmed that the residents' values and beliefs and her values and beliefs were being met by the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their cultural values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<p>Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Managers provide guidelines and mentoring for specific situations. Interviews with staff confirmed their awareness and understanding of</p>

harassment, sexual, financial, or other exploitation.		professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Many core clinical practices also have education packages for staff, which are based on Ryman policies.</p> <p>A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (head office) for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The system of data analysis and trend reporting is designed to inform staff at facility level. Management at facility level are then able to implement changes to practice, based on the evidence provided.</p> <p>Key areas of focus that have been determined for the 2021 year include preventing staff injuries by improving their knowledge and skills, improving the induction process for new staff, decreasing the number of pressure injuries and improving the life of residents by being more inclusive of all residents.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Fifteen incident/accident forms and corresponding residents' files were reviewed, and all identified that next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. There were two residents with English as their second language. Family and staff are used as interpreters in the first instance. Staff reported that they have learned some words in the</p>

		resident's language to assist with communication.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Bert Sutcliffe is a Ryman healthcare retirement village located in Birkenhead, Auckland. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care for up to 150 residents. This includes 30 serviced apartments that are certified to provide rest home level care. All 82 beds in the rest home and hospital floors are certified as dual-purpose, although at the time of the audit just the rest home floor is being used as a dual-purpose floor. Thirty-eight dementia level beds are separated into two nineteen bed units with a nursing station located between the two.</p> <p>During the audit there were 38 dementia level residents in the two 19-bed units, 41 hospital level residents and 35 rest home level residents including two residents in the serviced apartments. Three residents were on respite (rest home level) with one of the respite residents funded by ACC. The remaining residents were on the age-related residential care contract.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2021 are defined with evidence of regular reviews and quarterly reporting on progress towards meeting these objectives. Results are communicated to staff in the full facility meetings.</p> <p>The village manager was on extended leave during the audit. Her role is being filled by an acting village manager (non-clinical) who holds a background in the hospitality industry with seven years in elderly care and three years in a management role. She is the resident services manager at Bert Sutcliffe when not in the acting village manager's role. Plans are in place for her to work as the acting facility manager for one year. This appointment began in June 2021. She is supported by the clinical manager and acting resident services manager.</p> <p>The clinical manager has been in her role for two years with previous experience as a clinical nurse specialist in gerontology for the District Health Board (DHB) for 15 years.</p> <p>The acting village manager and clinical manager have completed a minimum of eight hours of education per year relating to their managerial roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient</p>	FA	<p>The clinical manager and acting resident services manager are responsible during the temporary absence of the village manager, with support provided from the regional manager.</p>

<p>and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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 facilities have a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the managers and staff; and review of management and staff meeting minutes, demonstrates their involvement in quality and risk activities.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and service delivery. There are clear guidelines and templates for reporting.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed showing trends in the data. Results are communicated to staff across a variety of meetings. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Resident meetings are held two-monthly. Minutes are maintained. Annual resident and relative surveys for the 2021 year reflect that the vast majority of residents and relatives are satisfied or very satisfied with the level of care provided. A quality improvement plan (QIP) is developed where opportunities for improvement are identified. The QIP is signed off when resolved. At the time of the audit, thirteen QIPs were documented for 2021 (year-to-date) with a range of QIPs already signed off in 2021 as fully implemented (reducing skin tears, reducing the number of falls for respite residents, addressing any lower scores received from resident/relative survey results, reducing the number of urinary tract infections, addressing a corrective action in relation to the housekeeping audit).</p> <p>Health and safety policies are implemented and monitored as evidenced in the monthly health and safety meetings. The acting village manager has overall responsibility for the health and safety programme. A health and safety representative (village support) was interviewed during the audit. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. The hazard registers for generic and specific hazards are reviewed a minimum of annually. The internal audit programme is linked to health and safety (e.g., food safety audits, emergency call bell audits, environmental audits, fire safety audits, waste management audits). Staff document hazards and near miss events in a designated book that is held at reception. All staff</p>

		<p>complete health and safety training during their induction to the facility. Reception staff and/or maintenance staff are responsible to orientating external contractors through the Assure electronic system.</p> <p>A range of strategies are implemented around reducing the number of residents falls including: review, discuss and monitor falls rates weekly, monthly and six monthly to identify risk factors and trends; hourly intentional rounding for identified high risk fallers and residents with vision impairment; carers handover to their buddy when they leave the floor; lounge carers remain in the lounge unless relieved by a caregiver or RN; residents are encouraged to attend the triple A exercise classes.</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>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of 15 incident/accident forms (witness and unwitnessed falls, pressure injuries, skin tears) identified that all electronic assessments relating to the adverse event were fully completed and included follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the management, clinical and staff meetings. Neurological observations are completed as per protocol if there is a suspected injury to the head.</p> <p>The acting village manager is able identify situations that would be reported to statutory authorities. Section 31 reports have been completed for one police investigation (absconding resident), two pressure injuries and change in managers since the previous audit. Notification was made to the DHB and public health authorities relating to one gastrointestinal outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (one clinical manager, one village support, one chef, one fluid assistant, four caregivers, one lounge assistant, one receptionist, one activities assistant, one dining assistant, one housekeeper, and one gardener) included a signed contract, job description relevant to the role of the staff member, evidence of staff completing their orientation programmes (general and specific to the position), police vetting and reference checks. Eight-week performance reviews are completed following employment and were evidenced as being completed annually thereafter.</p> <p>A register of registered nurse and enrolled nurse practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p>

		<p>The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme offered to staff exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Online training is complimented by in-service training and competency assessments. Nursing staff are supported to maintain their professional competency. Twelve of twenty RNs have completed their interRAI training. There are implemented competencies for nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies. All staff are required to complete yearly comprehension surveys.</p> <p>Eighty-four caregivers were employed at the time of the audit. Eight had achieved a level four Careerforce qualification (or its equivalent), seven had a level three qualification, and five had a level two qualification. A total of 16 caregivers have completed the dementia standards, 10 of these work in the dementia units. Of the 24 staff who work in the dementia units, 10 have completed the dementia standards. Four have completed and submitted the required paperwork and are awaiting their results. The remaining staff who work in the special care unit are in the process of completing their dementia qualification and have been working in the special care unit for less than 18 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. This defines staffing ratios to residents. Rosters implement the staffing rationale. The acting village manager is on-site Monday – Friday alongside the clinical manager who is an experienced registered nurse with a current practising certificate.</p> <p>There are thirty serviced apartments certified to provide rest home level of care that are located across six floors. Two rest home level residents were living in a serviced apartment at the time of the audit. The serviced apartment (SA) coordinator is an enrolled nurse and works Sunday – Thursday. An RN covers on the two days that the EN is not available (Friday/Saturday). The am shift is staffed with two long (eight hour) shift caregivers. The PM shift is staffed with two (short shift) caregivers (2100 and 2200). The remaining PM shift and night shift are covered by a designated hospital level caregiver. Staff communicate via pagers. One serviced apartment resident who was interviewed reported that staffing levels are adequate.</p> <p>Thirty-five rest home and two hospital residents were living in the rest home/hospital unit (4th floor). RN staffing includes a unit coordinator/RN five days a week (Tuesday – Saturday) and a staff RN (Saturday/Sunday). Two long shift and two short shift caregivers (0700 - 1300) cover the am and pm shifts (1500 - 2030 and 1500 -2100) and two caregivers cover the night shift. The RN is based in the</p>

		<p>hospital (3rd floor) and provides oversight during the pm and night shifts.</p> <p>Thirty-nine hospital level residents were living on the 3rd floor. A unit coordinator/RN is rostered five days a week. Two staff RNs are rostered for the am shift and pm shifts and one RN is rostered for the night shift. The hospital floor is supported by four long and four short (0700 - 1300) caregivers on the AM shift, two long and four short (1500 - 2100) caregivers on the PM shift and two caregivers on the night shift. A fluid assistant is rostered 0930 – 1300 and a lounge carer is rostered 1600 – 2000, both seven days a week.</p> <p>There are two secure dementia units (19 beds each) with a shared nursing office. Both dementia units were full with a total of 38 residents. A unit coordinator (RN) oversees both units five days a week (Tuesday – Saturday) and a staff RN is rostered the remaining two days of the week (Sunday and Monday). The RN in the hospital provides oversight for the pm and night shifts. Two long and two short shift (to 1300) caregivers are rostered in the am and pm shifts (to 2100). Three caregivers are rostered for the night shift. Lounge carers are rostered seven days a week from 0900 – 1600 and 1600 – 2000.</p> <p>Additional (guaranteed hours) staff who are employed to fill absences in the roster, referred to as cover pool staff, include 32 RN hours per week, 71 caregiver hours per week and 16 housekeeping hours per week.</p> <p>Activities staff are scheduled seven days a week in the hospital and dementia units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by the 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 to attend to residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry including information on the 48-hour complimentary service for village residents, short-term stays, rest home,</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>hospital and dementia level of care services. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term and short-term admission agreements were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and the DHB 'yellow envelope' process is used. The RNs report that they include copies of all the required information in the envelope. Resident files reviewed included admissions to and from public hospital and all procedures, including documentation had been completed appropriately.</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>	<p>FA</p>	<p>There are comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy.</p> <p>Registered nurses, enrolled nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Registered nurses have also attained syringe driver competency through the local hospice. There were two self-medicating rest home residents on the day of audit. Self-medicating competency, three monthly reviews, monitoring and safe storage were in place. The medication rooms were clean and well organised, all medications were in date and stored appropriately. The medication room and fridge temperatures are recorded, and these are within acceptable ranges. There are no standing orders in use and no vaccines are kept on site.</p> <p>Twenty-two medication charts were reviewed (six rest home, ten hospital and six dementia). Photo identification and allergy status was on all charts. All medication charts had been reviewed by the GP at least three-monthly. All resident medication administration signing sheets corresponded with the medication chart. All policy and legislative requirements had been met.</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</p>	<p>FA</p>	<p>The meals at Ryman Bert Sutcliffe are all prepared and cooked on site. The kitchen was observed to be clean and well organised. A current approved food control plan was in evidence which expires 9 May 2022. 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.</p>

<p>component of service delivery.</p>		<p>The assistant lead chef (interviewed) was aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. The service utilises pre-moulded pureed foods for those residents requiring that particular modification. Meals are plated by the chefs and delivered via hot boxes to the units where they are served by care staff in each of the unit kitchen/dining rooms. 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 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the myRyman system within the required timeframes for all residents entering the service including short-stay residents. InterRAI assessments had been completed for all long-term residents whose files were reviewed. Applicable myRyman assessments are completed and reviewed at least six monthly or when there is a change to residents' health/risk. The outcome of all assessments is reflected in the myRyman care plan. Behaviour assessments had been completed for the files of the three dementia care residents with the outcomes included in the care plan.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs, resident goals and provide detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. MyRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.</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>When a resident's condition changes the registered nurse initiates a GP/NP consultation. Registered nurses interviewed stated that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>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).</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. Current wounds two facility acquired pressure injuries (one stage 3 and one unstageable), sixteen skin tears, six chronic ulcers, two surgical wounds, four lesions and one abrasion. There has been input from the wound nurse specialist into pressure injury and chronic wound management. Photos of wounds demonstrated progress or deterioration. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically. An incident report and section 31 notifications were sighted for the pressure injuries.</p> <p>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</p>

		<p>resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</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>CI</p>	<p>A team of activity and lifestyle coordinators (including two qualified diversional therapists – DT), activity assistants, and lounge caregivers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The activity and lifestyle coordinators work Monday to Friday in each of the four areas (hospital, special care unit, rest home and serviced apartments) and are supported by weekend activity assistants. The rest home programme is Monday to Friday and the hospital and dementia unit is seven days a week. The special care (dementia unit) is split in to two units, with the activities and lifestyle coordinator based in one side and a lounge carer leading activity in the other.</p> <p>There is a monthly programme for each unit, delivered to each resident's room. A daily activity programme is written on the lounge whiteboard. Residents have the choice of a variety of Engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside.</p> <p>The rest home resident in the serviced apartment can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The village has two vans available for outings and a driver on staff available as required.</p> <p>The hospital wing utilises a contracted, wheelchair accessible vehicle for their outings.</p> <p>Activities in the dementia care units include triple A exercises, singing, happy hours, hand therapy, word and memory games. There are also low-sensory activities if required including manicures and hand-massage. Community group, entertainer and pet therapy visits occur in all units. Happy hour occurs weekly.</p> <p>During Covid-19 lockdown, the service-initiated hallway activities in all units, with coordinators providing entertainment, hosting quizzes and facilitating exercise sessions for residents who were unable to leave their room. Happy hour supplies were delivered to individual rooms and entertainment provided via the tablet situated in each resident's room. The service also activated zoom sessions for all residents to maintain communication with families, which was managed on a day-to-day basis by the activities team.</p> <p>There are interdenominational church services held weekly in addition to individual spiritual support visits in the residents' rooms as required. Special events like birthdays, Matariki, St Patricks day,</p>

		<p>Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.</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 resident files reviewed showed long-term care plans had six monthly reviews completed and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, NP, RNs, activities coordinators, physiotherapist and resident/family. Progress towards meeting goals were documented. Progress notes were completed and reflected response to interventions and treatments. Changes to care were documented. Documentation of GP/NP visits evidenced that reviews were occurring at least three-monthly. Short-term care plans were in use for short term issues.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance from specialist practitioners. The review of resident records included evidence of recent referrals to allied health professionals including mental health services, dietician and wound nurse specialist.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>

substances, generated during service delivery.		
<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>	FA	<p>The facility has three service levels across six floors (including serviced apartments). All care beds (dementia excluded) are dual-purpose; however, the service currently runs as floor 4 rest home/hospital, floor 3 hospital and floor 2 dementia. Floor 2 contains 38 dementia beds split in to two units with a central nurses' hub in-between. Independent serviced apartments are 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 Warrant of Fitness (BWOFF) expiring 11 June 2022.</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 January 2022. Hot water temperatures in resident areas are monitored, and 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 and secure access to the outdoor deck areas with raised gardens, seating and shade.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms within the facility have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are mobility toilets near all communal lounges. There are privacy signs on all toilet doors.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents can personalise their rooms and the rooms are large enough for family and friends to socialise with the resident.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are dining rooms in each area. The dementia units each have a separate dining room and main lounge with a smaller quiet sensory lounge. There is a, café, and hairdressing salon and beauty therapy room.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaners’ trolley sighted were labelled. The sluice rooms and the laundry are kept locked when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift and on outings. The village has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities are in place. There are civil defence kits in the facility and adequate water storage on-site to meet DHB requirements.</p> <p>The call bell system is evident in resident’s rooms, lounge areas, and toilets/bathrooms. The call bell system is linked to staff pagers and to the call bell panels. Residents can choose to wear an alarm pendant which is alarmed if they remove and walk away from it. Staff also use a telecommunications system to answer the phone at reception after hours and to communicate with each other if assistance is needed.</p>

		Security systems are being implemented to ensure residents are safe. Staff confirmed that they conduct security checks at night.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All bedrooms and communal areas have ample natural light and ventilation. Heating is a mixture of underfloor and individual heat pumps, all of which are thermostatically controlled. Staff and residents interviewed stated that these are effective. The entire site is smoke free.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control leader is the clinical manager. A job description defines the role and responsibilities for infection control. The infection prevention and control committee meet bi-monthly, and the programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection prevention and control leaders.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents have received both doses of the Pfizer Covid-19 vaccine (96%) with staff vaccination ongoing in conjunction with the local DHB. Residents and staff are offered the influenza vaccine. There has been one outbreak (norovirus) in 2020 which was appropriately managed and included liaison with the local DHB and public health unit.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene and use of PPE. During Covid-19 lockdown it was mandatory for staff not to travel to and from the facility in uniform, with changing facilities provided on site. Although this is no longer mandatory, it is strongly encouraged as being best practice.</p> <p>Ryman has a dedicated infection control channel on the ChattR app for information, education and discussion and Covid updates should matters arise in between scheduled meeting times. All visitors are required to provide contact tracing information.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	There are adequate resources to implement the infection control programme at Ryman Bert Sutcliffe. The infection control committee meet two-monthly, with information then being cascaded as part of staff meetings and also as part of the registered nurse meetings. The infection prevention and control leader

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		has completed training in infection control. The infection prevention and control leader has access to an infection prevention and control nurse specialist from the DHB, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection prevention and control leader is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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 the clinical manager (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 Bert Sutcliffe 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 using power BI.</p>

		There has been one outbreak in December 2020 which was appropriately managed.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. The clinical manager is the restraint coordinator. Restraints have not been used at the facility since 2016 with the exception of one (hospital) resident who was recently placed in a specialised chair following a fall with injury. There were no enablers in use at the time of the audit.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical manager is the restraint coordinator for the facility. The role and responsibilities of the restraint coordinator are defined in the restraint coordinator job description. A range of strategies are implemented by the restraint coordinator and staff to ensure that restraint is only used as a last resort.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment that meets criteria (a) – (h) is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, approval group, resident and their family/whānau undertakes restraint assessments. These assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form was completed for the resident requiring a special (Viking) chair. This chair prevents him from standing and was implemented following a fall with facial fracture approximately one month ago. It is being used instead of a lap belt with the resident displaying no eagerness to stand or agitation while in this chair.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>There is an up-to-date restraint register that indicates restraint has not been used at this facility since 2016 with the exception of one (hospital) resident who has recently been placed on a restraint. The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Discussions took place between the restraint coordinator and Ryman Christchurch prior to placing the resident in a special chair and is being used as an alternative to a lap belt restraint. The reason for the restraint was that the resident was at risk of harming himself due to his high risk of falling.</p> <p>Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored on an hourly schedule. If the resident becomes agitated, strategies are implemented to settle him including one on one specialising. Restraint use, risks and cares to be carried out during the restraint episode are documented in the care plan.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluations occur three-monthly (at a minimum) as part of the ongoing reassessment for residents on the restraint register although the resident using restraint at the time of the audit is being reviewed monthly. Families are included as part of this review where possible</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint usage throughout the Ryman organisation is monitored regularly. The review of restraint use is discussed at an organisational level and at relevant facility meetings. The Ryman organisation and facility are very proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes staff completing a competency in relation to restraint minimisation.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>All residents are assessed at admission and in an ongoing manner to establish interests and skills and a plan is developed for the residents around activities. The activity programme was reviewed and adapted to continue the provision of engaging residents in meaningful activities during a period of pandemic lockdown restrictions. This resulted in continued resident engagement, physical activity, social interaction and resident satisfaction.</p>	<p>Due to pandemic restrictions in parts of 2020, residents were unable to attend group activities and at times were unable to socialise with other residents and/or have visitors.</p> <p>The resident survey results in February 2020 had a score of 3.94. Despite the lockdown, the activities team adapted the program to enable resident participation in virtual groups through the use of technology and the provision of remote activity facilitation, including virtual happy hour, zoom sessions and the maintenance of contact with family and friends. This resulted in an improved resident satisfaction survey result, related to activities of 4.21 in February 2021. Interviews with residents during audit confirmed their satisfaction and engagement with the activities team and program.</p>

<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	<p>CI</p>	<p>Restraint has not been used at this facility since it opened with the exception of one resident who poses a risk of harming himself and has recently been placed in a reclining chair.</p>	<p>The facility has maintained a restraint-free environment, using it only as a last resort. This has recently been the case for one hospital level resident. A number of strategies have been implemented to achieve a restraint-free environment. Staff are provided education on restraint, the risks of restraint, what constitutes restraint, interventions strategies, accountability and legality; residents and families are well-informed regarding the facility's goals of maintaining a restraint-free facility and the benefits that this has for residents; falls prevention strategies are implemented with a low falls rate maintained; safe staffing levels are in place, which include lounge carers and fluid assistants; specialling of residents is permitted for up to ten minutes at a time before other strategies are commenced (e.g., pet therapy using lifelike imitations).</p>

End of the report.