

# Anthony Wilding Retirement Village Limited - Anthony Wilding 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).

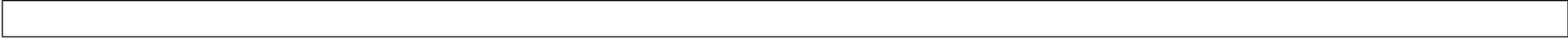
The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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:

<b>Legal entity:</b>	Anthony Wilding Retirement Village Limited
<b>Premises audited:</b>	Anthony Wilding 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: 9 September 2021      End date: 10 September 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>	151



# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Anthony Wilding Retirement Village is operated by Ryman and provides rest home, dementia and hospital level care for up to 178 residents, including 30 serviced apartments certified to provide rest home level care. At the time of the audit there were 151 residents in total including seven rest home residents in the serviced apartments.

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

The village manager (non-clinical) has been in the role for four years, previously being the assistant to the manager for three years. She is supported by a clinical manager has been in her role for six years and has past experience in aged care in clinical management roles. They are supported by an assistant to the manager, five-unit coordinators, RNs and caregivers. The management team is supported by the Ryman management team including regional manager.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisation's quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified no areas of improvement.

The service is commended for achieving continuous improvement ratings around recognition of falls prevention, activities, maintaining a restraint free environment and infection surveillance.

## 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.
--	--	--

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints.

## 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.
---	--	--

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Village objectives 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. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. 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.		All standards applicable to this service fully attained with some standards exceeded.
--	--	---

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy with an ensuite. There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on site.

There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management training.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.
---	--	---

Restraint minimisation is practiced and overseen by the registered nurse. There were no residents using enablers or restraints. Staff receive training around restraint minimisation and management of challenging behaviour.

## 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.

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer has attended 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 officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	3	42	0	0	0	0	0
<b>Criteria</b>	4	89	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 1.1.1: 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 (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 (village manager, assistant to the manager, clinical manager and regional operations manager) and 28 care staff; including four-unit coordinators, six registered nurses (RNs), one enrolled nurse (EN), 12 caregivers (two dementia, seven hospital, two rest home and one serviced apartments) and five activities staff described how the Code is incorporated into their working environment. 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 information they need to make informed choices and give informed consent.</p>	FA	<p>Thirteen resident files were reviewed, (three rest home including one serviced apartment resident, three dementia residents including one respite resident and seven hospital level of care). Informed consent processes had been discussed with residents (as appropriate) and families on admission. Completed resuscitation and general consents were sighted on the electronic files including for Covid-19 and influenza vaccination. Advance care plans where known were available on the resident files.</p> <p>There was evidence of discussion with family when the GP completed a clinically indicated 'not for</p>

		<p>resuscitation' order where residents were deemed not to be competent and had a needs assessment on file. Discussions with staff, confirmed verbal consent is obtained for entering rooms and when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Family/whānau discussions were evident in the progress notes.</p> <p>Residents' records also included enduring power of attorney (EPOA) documents. All three residents' records reviewed from the dementia unit evidenced an approved needs assessment for the service and all included a nominated and enacted EPOA. Signed admission agreements were evident in the resident's electronic records.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files included information on the resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included 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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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 relatives, confirmed their understanding of the complaints process. Staff interviewed were able to 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. Four complaints received in 2021 (year to date) and two complaints made in 2020 have been managed in a timely manner and are documented as resolved.</p> <p>One of the complaints made in 2020 was made through the Health and Disability Commissioner (HDC), who referred the complaint to the Nationwide Health and Disability Advocacy Service. The</p>

		complaint was investigated and was resolved in October 2020.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>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. Nine relatives (two rest home, three hospital and four dementia care) and nine residents (six rest home and three hospital care) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support resident privacy and confidentiality. 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 while cares were being done. 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 to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into resident cares. Staff attend education and training on abuse and neglect, last completed in June 2021.</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 is encouraged in assessment and care planning and visiting is encouraged. The service has links with the local Māori iwi for advice and support as required. There was one resident who identified as Māori at the time of the audit. Cultural needs were addressed in the resident's care plan.</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</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 multidisciplinary 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</p>

respect their ethnic, cultural, spiritual values, and beliefs.		account their values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (formerly known as 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 teamRyman 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 the facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a 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.  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. Fifteen incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is

		available if needed, for residents who are unable to speak or understand English.
<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>Anthony Wilding is a Ryman healthcare retirement village. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care for up to 178 residents. This includes 30 serviced apartments that are certified to provide rest home level care.</p> <p>On the day of the audit there were 151 residents including seven residents in the serviced apartments receiving rest home level care. The rest home unit has 35 beds with full occupancy, including two private residents not on an aged residential care service agreement. There are two hospital units, Canterbury unit has 40 beds with full occupancy and the Wimbledon unit has 40 beds with 38 occupied. All hospital rooms are dual-purpose. The special care unit (dementia) unit has 33 beds, with 31 occupied, including one resident on respite.</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values and beliefs are documented that are specific to Ryman Anthony Wilding. Four village objectives for 2021 (drive audit compliance, improve clinical indicators, improve resident and relative experience and drive positive team culture) are defined with evidence of reviews in April and August 2021 on progress towards meeting these objectives. Objectives and the progress towards meeting these objectives are posted in the staff room.</p> <p>The village manager (non-clinical) has been in the role for four years, previously being the assistant to the manager for three years. She is supported by a clinical manager who has been in her role for six years and has past experience in aged care in clinical management roles. They are supported by an assistant to the manager, five-unit coordinators, RNs and caregivers. There are weekly management meetings. The village manager reports to the regional operations manager who reports to the operations manager.</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision</p>	FA	<p>The clinical manager is responsible during the temporary absence of the village manager, with support from the assistant to the manager, regional operations manager and Ryman management team.</p>

<p>of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Ryman Anthony Wilding has a well-established quality and risk management programme that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings (full facility, management, clinical, health and safety, infection control meetings) and reported to the organisation's management team. Discussions with the management team and staff, and review of meeting minutes demonstrated their involvement in quality and risk activities. Annual resident and relative surveys are completed. Results and any areas for improvement are fed back to staff and participants through resident (two-monthly) and relative (six-monthly) meetings. The resident's overall satisfaction average score was 4.24 and the relatives' overall satisfaction rate was 4.30. Corrective actions have been established around housekeeping and linen services.</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. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored at the monthly health and safety committee meeting. The noticeboard keeps staff informed on health and safety meetings. The staff health and safety officer (caregiver) was interviewed. He has completed level two external health and safety training. The health and safety officer facilitates fire drills and provides education on emergency procedures in small groups from each unit throughout the year. The risk register is reviewed annually and updated prior to each meeting with new hazards added as appropriate. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. There is a focus on identifying and reporting hazards through the new Donesafe app. Ryman Christchurch sends out health and safety bulletins regularly and alerts for staff information and awareness.</p> <p>Falls prevention strategies are in place that include ongoing falls assessment, reviewing call bell response times and routine checks of all residents specific to each resident's needs. All falls are fully investigated, medical causes identified and treated, location and timing of falls analysed for trends and ongoing education includes manual handling, hoist refreshers, intentional rounding and use of equipment such as sensor mats, physiotherapy input and encouragement in exercise programmes.</p>

		Case studies are discussed at clinical meetings. General practitioners (GP) are notified of falls and a medical review including medication review is completed. Care plans record falls prevention strategies that reflect the residents falls risk. Falls prevention and management training has been held at a full facility meeting in April 2021 for all staff to attend.
<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, relative notification and any follow-up action required. There was a QIP in place to look at reducing the number of pressure injuries in 2021. A review of 15 electronic incident/accident reports for August 2021 were reviewed and identified that all were fully completed and included follow-up by a RN. Neurological observations are completed for unwitnessed falls and where there is an obvious knock to the head. The unit coordinators and managers review adverse events as part of the weekly management meeting.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. There were nine section 31 notifications made in 2020, including one health and safety incident and eight pressure injuries (seven unstageable and one stage three). In 2021 year to date three notifications have been made for three pressure injuries (two unstageable and one stage three). Notification has also been made to Public Health authorities for one outbreak (gastro) in June 2020.</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 policies including recruitment, selection, orientation and staff training and development. Fifteen staff files reviewed (one clinical manager, four-unit coordinators, one RN, seven caregivers, one activities coordinator and one chef) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN, EN and health professional practising certificates are maintained and current. An orientation programme provides new staff with relevant information for safe work practice. There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies.</p> <p>There is a completed annual education plan for 2020 and the plan for 2021 is being implemented. The annual training programme exceeds eight hours annually. Additional toolbox sessions are provided. Registered nurses are encouraged to attend external training, including sessions provided by the local DHB. Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session. Staff are also required to complete a series of</p>

		<p>comprehension surveys each year. There are 26 RNs working at Ryman Anthony Wilding and 13 have completed interRAI training. There are 102 caregivers in total. Approximately 90% of caregivers have attained their national certificate in aged care. Twenty seven of thirty caregivers who work in the special care unit have completed their dementia standards qualification. Three caregivers are in progress of completing and have been employed 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 village manager, assistant to the manager and clinical manager all work Monday to Friday. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p> <p>There were 35 rest home residents in the rest home unit (35 beds). A rest home unit coordinator (RN) works from Tuesday to Saturday and an RN covers on the two days that the unit coordinator is not available. One RN is rostered Monday to Friday 9 am to 1 pm. They are supported by four caregivers on the morning shift (two long and two short), three caregivers (one senior) on the afternoon shift (two long and two short) and two caregivers (one senior) on the night shift.</p> <p>There were 39 hospital residents and one rest home resident in the Canterbury, hospital unit (40 dual-purpose beds). A hospital unit coordinator (RN) works from Tuesday to Saturday. There are two RNs on morning and afternoon shifts and one on the night shift. They are supported by eight caregivers on the morning shift (four long and four short), six caregivers on the afternoon shift (two long and four short) and two caregivers on the night shift. A fluid assistant and physiotherapy assistants work from 9.30 am to 1 pm and a lounge carer works from 4 pm to 8 pm.</p> <p>There were 37 hospital residents and one rest home resident in the Wimbledon, hospital unit (40 dual-purpose beds). A hospital unit coordinator works from Tuesday to Saturday. There are two RNs on morning and afternoon shifts and one on the night shift. They are supported by eight caregivers on the morning shift (four long and four short), six caregivers on the afternoon shift (two long and four short) and two caregivers on the night shift. A fluid assistant and physiotherapy assistants work from 9.30 am to 1 pm and a lounge carer works from 4 pm to 8 pm.</p> <p>There were 31 dementia residents in the special care unit (33 beds). A dementia unit coordinator works from Sunday to Thursday. There is one RN on the morning and afternoon shifts. They are supported by four caregivers on the morning shift (one long and three short), three caregivers on the afternoon shift (one long and two short) and two caregivers (one senior) on the night shift. A RN from the hospital unit covers the special care unit overnight.</p> <p>There were seven rest home residents in the serviced apartments (30 beds). A serviced apartment unit coordinator/EN works from Tuesday to Saturday and a senior caregiver covers the two days that</p>

		<p>the unit coordinator is not available. They are supported by two caregivers (one senior) on the morning and afternoon shifts (one long and one short). A RN from the hospital unit covers the rest home residents in the serviced apartments overnight.</p> <p>Extra staff can be called on for increased resident requirements. A cover pool has been implemented whereby (extra) care staff are scheduled to work Friday to Monday to cover absences. Additional casual staff are available if needed.</p> <p>Activities staff are scheduled seven days a week in the hospital and special care units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered seven days a week.</p> <p>Staff were visible and were attending to call bells in a timely manner as observed by the auditors during the audit. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support.</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>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident information (hard copy and electronic) is protected from unauthorised access. Entries are legible and dated by the relevant care staff or registered staff, including their designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are implemented 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 short-term stays, rest home, hospital and dementia level of care services. The admission agreements reviewed met the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements including the one short-stay admission agreement for funded respite were signed and dated.</p> <p>The clinical manager described the admission process including the service reviewing all admissions and discussing the admission with the family and resident prior to admission.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</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 in place for all aspects of medication management. Registered nurses, enrolled nurses and caregivers, who have passed their medication competency, administer medications. There were six residents (three hospital and three rest home including one in the service apartment) self-administering eye drops, inhalers and nose sprays on the day of audit. Assessment and monitoring of self-medication occurs. Medications were stored in a locked drawer in residents' rooms and administration of medication is verified by the registered nurse. Specific medication risks are identified in the care plan and include but not limited to warfarin, insulin and beta-blockers.</p> <p>There are four medication rooms on site, one for each level of care and all have secured keypad access. Medication's fridges had weekly temperature checks recorded and were within normal ranges. Medication room temperatures are monitored daily and do not exceed 25 degrees. Medication stocks are checked weekly and medication registers comply with the relevant guidelines.</p> <p>Medication competencies are updated annually and include syringe drivers, subcutaneous fluids, blood sugars, warfarin, enteral feeds and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The service does not use standing orders. Medication errors are reported on an incident form and part of quality data and discussed at meetings. Medication training was completed in April 2021.</p> <p>The facility utilises an electronic medication management system. Twenty-six medication profiles were sampled (fourteen hospital, six rest home including one serviced apartment, and six dementia level of care). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of 'as required' medication administered was documented in the electronic prescription.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where</p>	<p>FA</p>	<p>The service has a well-equipped commercial kitchen on site where all food and baking is prepared and cooked. The qualified head chef is supported by one other chef and cook, a weekend cook and a team of four kitchen assistants. Staff have been trained in food safety. Project "delicious" has continued to be the focus of meal delivery. The dining room experience is for enthusing the appetite. The seasonal menu has been designed in consultation with the dietitian at an organisational level.</p>

<p>this service is a component of service delivery.</p>		<p>Twenty percent (20%) of the menu is changed every menu review.</p> <p>Menu choices are decided by residents (or family/EPOA/primary care staff if the resident is not able) and offer a range of choices for main dishes for the midday and evening meal including a vegetarian, gluten free and light meal option. Diabetic desserts and modified diets are accommodated. All meals are delivered in hot boxes to each unit's satellite kitchen, where it is placed in bain maries for service. The chef receives a dietary profile for all new resident admissions and is notified of any dietary changes. Resident likes and dislikes are accommodated and listed on the daily spreadsheet. Alternative foods are available on the menu or offered. Cultural, religious and food allergies are accommodated. Nutritious snacks and fruit platters are available 24 hours a day. There is a supply of snacks (including a nibble platter) in the dementia unit kitchenette. The service provides protein increased shakes for residents with wound management.</p> <p>Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained for the chef, cook and kitchenhands. Staff were observed to be wearing appropriate personal protective clothing. The food control plan was verified and expires on the 9 May 2022.</p> <p>There are two fluid assistants (one in each hospital wing) working morning shift that assist residents with adequate fluid intake.</p> <p>Residents can provide feedback on the meals through resident meetings, food communication books in each servery, resident survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</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 residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>In the files reviewed, risk assessments had been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural and wound were completed according to need.</p>

manner.		<p>The service has used the myRyman electronic resident individualised care programme. There are a number of assessments completed that assess resident needs. The assessments generate interventions and a narrative completed by the RNs that are automatically transferred to the care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs are met. Thirteen resident files were reviewed (seven hospital, three rest home including one resident in a serviced apartment and three dementia care including respite care). Twelve files included up-to-date long term care plans that included interventions to support all current needs. The resident on respite care in the dementia unit had a comprehensive initial care plan to reflect all current needs.</p> <p>One hospital resident receiving end of life care reflected current assessed needs that were regularly updated. Three files were reviewed of residents in the dementia unit. All three included integrated activities of daily living that supported activities/interests across 24/7. Behaviour management/de-escalation plans were documented where assessed as needed.</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 (but not limited to); current infection, wound or recent fall. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Residents and relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record.</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>	FA	<p>When a resident's condition changes the registered nurse initiates a GP or nurse specialist consultation. A registered nurse 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. Communication 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.</p>

		<p>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). 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.</p> <p>There were four wounds registered in the rest home with no pressure injuries. There were 14 documented wounds in the hospital, two residents had five wounds between them and evidence of a resolved stage three sacral pressure injury. There were no residents with current pressure injuries. There were five residents with wounds in the dementia unit, and no recorded pressure injuries.</p> <p>All residents with wounds documented at least a monthly review as well as scheduled, ongoing wound evaluations as part of routine wound care. There has been input from the GP and wound care nurse specialist as required. Photos of wounds demonstrated progress towards healing. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically. Wound care training has been provided in May 2021 as part of the RN journal club. The wound care RN stated that the service focus is on reducing skin tears and bruising through good skin care and manual handling training for staff.</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 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>The activity team and lounge carers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The team includes three qualified diversional therapists and three activity staff for the rest home, hospital and the dementia unit as well as two further activity staff for the serviced apartments. There is also a van driver. The rest home and serviced apartment programme is Monday to Friday and the hospital and dementia units are seven days a week. There is an activity person in the special care unit and hospital in the evenings who, in conjunction with the care staff, ensures that activities and support are always available to the residents.</p> <p>There is a monthly programme for each unit in large print on noticeboards and some residents also</p>

		<p>have a copy in their rooms. 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. The rest home residents in serviced apartments 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 service has two vans, a company car and a golf cart. There are regular combined activities and celebrations held in the large lounges and atrium for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision.</p> <p>Activities in the dementia care units include triple A exercises, garden walks in the two courtyards and around the village, singing, happy hours, hand therapy, word games, knitting group and dancing. Resources are plentiful. Cultural groups and pet therapy visit (to all units).</p> <p>There are interdenominational church services held in the chapel with room visits as required. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated. Junior school children and kapa haka groups visit.</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>The service has been awarded a continuous improvement around providing residents with engaging activities amidst restrictions of the ongoing pandemic.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The eight of eleven long-term resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs, three hospital level residents have not yet been in the facility six months. The respite care resident file and resident on palliative (end-of-life) care documented reviews and updates to care as needed.</p> <p>The multidisciplinary review involves the RN, GP, caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one to three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</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>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied professionals.</p> <p>Dementia files sampled included documented evidence of input from mental health services for older people, including the nurse specialist and the geriatrician.</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 substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies to guide staff in waste management of general waste, medical waste and sharps. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for staff in the laundry, housekeeping and sluice rooms. Infection control policies state specific tasks and duties for which protective equipment is to be worn. There is a documented process to clean reusable protective eyewear. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The two buildings have a current building warrant of fitness that expires 1 December 2021. A recent amendment to the fire evacuation document was done to accommodate a change in assembly areas following the last evacuation drill (14 April 2021), this has been approved on 30 June 2021. The service is divided into two buildings. The main building includes eighty hospital beds; divided into two units of 40 beds each (Wimbledon and Canterbury) and the serviced apartments. The rest home and dementia care (upstairs) units are in another building that is easily accessible by a connecting pathway (approximately five metres). There is a lift between the floors. The service has a chapel, library service, hairdressers and shop for all residents to access.</p> <p>Since the last audit a clinical room had been repositioned to a larger area in the hospital unit and an archive room refurbished to be a sluice room in the Wimbledon wing in the hospital unit.</p> <p>The following proposed changes are planned for the main building in 2022: refurbishment of the Village centre including the arcade, lounge and bar, refurbishment of reception area to include a café, refurbishment and extension of laundry, kitchen and hospital dining room. The architectural plans are awaiting council consent.</p> <p>The maintenance team address any maintenance requests or call on contractors as required. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical</p>

		<p>equipment, functional testing of electric beds and hoists and electrical testing. An appliance asset list is maintained for facility and resident electrical equipment. Each unit has its own water supply with tempering valves on each cylinder. Hot water temperatures in resident areas are monitored monthly and stable between 43-45 degrees Celsius. A recent corrective action plan had been implemented for July 2021 when water temperatures were between 36 and 39 degrees Celsius for the rest home; the problem was resolved.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. There are five centrally located nurses' stations (including one for the service apartments) across the service. Service apartments are spacious to meet safe mobility and safe care requirements.</p> <p>There is a team of grounds and garden staff that maintain the external areas. There are well maintained landscaped outdoor areas including four courtyards. Residents are able to access the outdoor gardens and courtyards safely from all units. Seating and shade is provided.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including the following equipment: sensor mats, sensor light and bed sensor pads (dementia care unit), standing and lifting hoists, tilting shower chairs, hospital level lounge chairs, mobility aids, transferring equipment, wheel-on and chair scales, pressure relieving mattresses and cushions, electric beds and ultra-low beds</p> <p>There are quiet, low stimulus areas that provide privacy when required.</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 bedrooms in all areas have single ensuites, access to a handbasin and flowing hand soap. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. There are separate toilets for staff and visitors in each unit.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	FA	<p>Each unit has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library area that is available for quiet private time or visitors. Serviced apartments also have a lounge area. The communal areas are easily and safely accessible for residents and staff.</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		There is adequate internal and external space to allow maximum freedom of movement while promoting safety for those that wander. The dementia care unit has a secure courtyard with safe paving and walkways with entry and exit points within the secure facility. There are seating and shaded areas. There are raised gardens and vegetable gardens
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has large communal lounges in each area which is used for group activities and entertainment. Each unit has a large lounge and dining area with other smaller seating areas. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise.</p> <p>The dementia care unit has an open plan lounge and dining room with a safe kitchenette area. There are seating alcoves with items of memorabilia. There are accessible communal lounges for residents in apartments. Rest home residents in the apartments have their meals in the dining room or their apartment.</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>	FA	<p>The external chemical provider monitors the effectiveness of chemicals in the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. Cleaning trolleys are kept in locked designated areas 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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Staff have attended emergency and disaster management training. The facility has an approved fire evacuation scheme in place and fire drills take place six-monthly. The last fire evacuation drill occurred on 14 April 2021. Smoke alarms, sprinkler system and exit signs are in place. There are staff employed across the facility 24/7 with a current first aid certificate. There are first aid kits located at reception, kitchen, facility van and maintenance shed. Battery operated emergency lighting is in place which runs for at least four hours. The facility has two on-site diesel generators to run essential services (one for the hospital and main building and one for the rest home and dementia unit).</p> <p>There is a civil defence kit located on each level which are checked monthly. Supplies of stored drinkable water is available. There is sufficient water stored to ensure 20 litres per day for seven</p>

		<p>days per resident. There are alternative cooking facilities available with two gas barbeques and ten gas bottles. There is an effective call bell system in all bedrooms, ensuites communal areas and service apartments. The call bells and door alarms are linked to pagers carried by staff. Calls light up on the screen panels in the hallways. Staff advise that they conduct security checks at night, in addition to an external contractor. A security camera is installed in the dementia unit only. The facility is secure after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility, heat pumps in the lounges and medication rooms and ceiling heaters in the hallways. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is the clinical manager covering for an RN who is on maternity leave. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets two-monthly. 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 control officers. On the day of audit, Anthony Wilding was operating effectively under level two lockdown guidelines.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control committee (combined with the health and safety committee) meet two-monthly. The infection control officer is allocated time each month to collate infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections. The infection and prevention officers have access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p> <p>Ryman Covid-19 strategies have been implemented within the facility. There are robust processes documented and include a full monthly stocktake of personal protective equipment. The result of the</p>

		stocktake are sent to the offsite Ryman warehouse in Christchurch which ensures PPE stocks are replenished. Staff were observed practicing good hand washing techniques.
<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	<p>The infection control officer is responsible for coordinating/providing education and training to all staff, and she has attended external training for her role. 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. There is regular education around Covid outbreak management to ensure staff are fully aware of protocols when lockdown levels change.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	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 and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the two monthly combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and

		<p>graphs are displayed.</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, identify any areas for improvement and education needs within the facility.</p> <p>There has been one small outbreak involving a suspected gastro outbreak in June 2020. This was contained and public health and the DHB were informed.</p> <p>The service has been awarded a continuous improvement for the reduction of urinary tract infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>CI</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>During the audit, there were no residents using enablers and no residents with restraints. The service has maintained being restraint free since February 2020. The restraint coordinator (currently a hospital unit coordinator) provides staff training around restraint minimisation and de-escalation of challenging behaviours.</p> <p>The service has been awarded a continuous improvement for maintaining a restraint free environment.</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
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Robust systems are in place for the collection, analyses, and evaluations of quality data. A range of data is collected around falls, skin tears, pressure injuries, and infections across the service through myRyman. Data collated is used to identify any areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management, full facility and clinical/RN meetings). Templates for all meetings document action	Falls in the hospital unit were identified as an area that required improvement from data collected from 2019/2020. A continuous improvement plan was developed in June 2020 which included identifying residents at risk of falling, reviewing call bell response times, routine checks of all residents specific to each resident’s needs, hourly intentional rounding for identified high risk fallers, staff complete ‘step back’ cards to heighten the awareness of residents with falls risk, reviewing the roster to ensure adequate supervision of residents, the use of sensor mats and night lights, proactive and early GP involvement for residents post falls and review of underlying causes for falls including medications, and increased staff awareness of residents who are at risk of falling.  The plan has been reviewed monthly and discussed at leadership and clinical meetings, with fall prevention strategies reviewed and the residents’ underlying conditions considered. Education and training for staff has been provided on manual handling, safe transfers, hoisting, positioning in bed and chair, safe use of equipment, uses of sensors and devices, managing distressed behaviour and promoting nutrition/hydration. Caregivers

		<p>required, timeframe, and the status of the actions.</p> <p>Falls are discussed at the leadership meetings, with fall prevention strategies reviewed, and the residents' underlying conditions considered. The falls assessment tool is completed, and falls protocols are monitored and followed up post falls. The clinical manager reviews the call bell report daily, and copies are provided to the unit coordinators. The physiotherapist review changes in resident mobility and a lounge carer is in the lounge monitoring residents. Residents at risk of falling are encouraged to join the exercise programme. Falls and incidents are discussed at the handovers between shifts to ensure staff are up to date with current information.</p>	<p>interviewed were knowledgeable regarding preventing falls and those residents who were at risk. The outcome of the plan has been that hospital falls rates in June 2020 were at 9.08/1000 occupied bed nights, the rate of falls continued to reduce with the rates in July 2021 being at 5.64/1000 occupied bed nights.</p>
<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>	<p>CI</p>	<p>A review of the resident survey in 2020 identified an opportunity to improve resident engagement and satisfaction with meaningful activities that would enhance their quality of life. Ryman Anthony Wilding continues to implement the Ryman organisational activities programme with a focus on alternatives which encompass the specific needs of Covid restrictions. There is the flexibility to add activities identified by residents as interests or recreational preferences. The service has been successful in providing alternative</p>	<p>The programme aims were identified, and an action plan developed to ensure meaningful activities were implemented during Covid restrictions. To achieve this, the activities team identified alternative activities using zoom such as virtual happy hours in conjunction with individual goodie bags delivered to rooms, online group activities and video calls to families. Other options to continue activities involved using PPE and physical distancing. The service identified the residents who are at risk of isolation and prioritised those residents for one-on-one intervention and facilitated other services such as volunteers and additional therapies. The service reviewed the activities programme each month and focused on providing activities with highest engagement levels. Evening activities were provided in the hospital and special care units.</p> <p>Once Covid restrictions lifted, the service focused on extending activities around special events such as World Buskers' festival, Waitangi Day,</p>

		<p>activities using a variety online platform.</p>	<p>Matariki, America's cup, Active aging week, World of Wearable Art, Armistice day, Māori language week, Pink Ribbon breakfast, Royal New Zealand Ballet – sleeping beauty, and the Ryman Olympics.</p> <p>There is documented evidence of resident enjoyment and positive relative feedback in resident and relative meeting minutes (sighted). Verbal feedback was received on the day of audit from resident and relative interviews. Positive messages from families about the activities programme were viewed on social media and on feedback forms. Monthly attendance rates at all activities were viewed and apart from allowances for lockdown, attendance demonstrated a continuous increase over the last 18 months. Activity sessions viewed during audit days demonstrated a high level of attendance and engagement in all areas. The resident's satisfaction survey in February 2020 reports a satisfaction rate of 3.89/5. After a year of focusing on the project aims and the action plan, the February 2021 survey reports a satisfaction rate of 3.95/5 demonstrating an improvement.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Ryman Anthony Wilding is proactive in developing and implementing quality initiatives. Quality improvement plans (QIP) are developed where results do not meet expectations. There is a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. 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 the facility level. Management at facility level are then able to implement changes to practice, based on the evidence provided.</p>	<p>The service has consistently maintained a low rate of urinary tract infections. It was identified that there was an opportunity to not only maintain but also further reduce the incidence of urinary tract infections in all areas. An action plan was implemented.</p> <p>Ryman Anthony Wilding implemented strategies for the reduction of urinary tract infections. Strategies included standardising clinical diagnosis of UTIs to ensure appropriate treatment, increasing fluid intake by identifying and providing residents with their specific preferred options and sanitising of communal toilet chairs between residents. Continuous training for staff was provided on UTI prevention and the importance of maintaining low rates of infection. Annual training on closing the loop – nutrition, hydration and UTI prevention and three-monthly caregiver comprehension surveys ensured staff were aware of their role in preventing UTIs. Related information was discussed at handover. The guidelines for treating UTIs were discussed with the GP based on information from the medication advisory committee. The service has been working with the GP service about antibiotic stewardship. Prophylactic antibiotics were discontinued where it was safe to do so. Regular review of all residents along with pharmacy input has enabled this downward trend and ensured regular evaluation and review of antibiotic use. Residents experiencing regular urine tract infection were identified and</p>

			<p>individual detailed strategies were documented in the resident's care plan. Documentation reviewed identified that individual strategies were regularly evaluated</p> <p>Infection data including UTI related data is available for all staff to view and recorded in the relevant meeting minutes. The programme plan was reviewed at weekly management meetings and three-monthly clinical indicator reports. Since July 2020, urinary tract infections across the three service levels have reduced from 3.9 to 1.2 in December 2020. The trend has continued with 0.95 per 1000 bed nights in April 21 to 0.74 in May per 1000 bed nights and 0 in June 2021. The monthly graph demonstrates a continued and sustained downward trend since July 2020 apart from two spikes which could be explained by an individual resident ill health.</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>A review of the clinical indicator data in May 2020 indicated Anthony Wilding Retirement Village to be restraint free since February 2020. The unit coordinators, clinical manager and village manager interviewed confirmed that a range of initiatives are implemented to ensure the restraint free environment is maintained. Meeting minutes reviewed evidenced discussions around strategies to maintain a restraint free environment. Care staff interviewed could explain current strategies that assist to keep the environment restraint free.</p>	<p>The service wanted to continue to support residents' independence and safety with proven strategies and initiatives that maintains the restraint free environment. This includes:</p> <p>Individual strategies to respond to specific resident needs including falls prevention, early intervention to identify changes in behaviour, quality use of medication, safe environment for wandering including a dementia friendly design with low stimulus areas, review of timing of other activities and individual schedules/routine.</p> <p>Ryman is committed to their responsibility of providing adequate staff levels and skill mixes to meet the needs of the residents. Rosters include physiotherapy assistants in each hospital unit to promote residents' independence through mobility support and exercise, lounge carers oversee residents in the lounge area in the dementia unit and hospital and assist with supervision, activities and de-escalation where required, and fluid assistants in the hospital unit ensures residents are adequately hydrated. Education sessions for staff were provided to include dementia related training to demystify dementia, restraint minimisation practices and management of challenging behaviours. This resulted in an increased understanding of the importance of early intervention, encourage staff input into residents' cares and empower staff through accountability.</p> <p>The strategies allow for early interventions of distressed behaviour. Staff aim to understand the unmet need, identify trends in times or locations, and</p>

			<p>incorporate this into the care plans. This has resulted in a calm environment and low usage of antipsychotic medications. The GP interviewed commented that care staff were good at redirecting behaviours. The data evidenced the service maintained the restraint free environment since the start of the initiative with no incidences of restraint or enablers reported. Quality data related to incidence of challenging behaviour per 1000 bed days has decreased since between May 2020 and July 2021. The care delivery and communication ratings in the annual survey for February 2021 increased from 4.41 to 4.49 and from 4.19 to 4.43 respectively.</p> <p>These findings were discussed at the upcoming clinical and quality meetings and monthly residents' newsletters.</p>
--	--	--	--

End of the report.