

Murray Halberg Retirement Village Limited - Murray Halberg Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

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| Legal entity: | Murray Halberg Retirement Village Limited |
| Premises audited: | Murray Halberg 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: 14 January 2022 End date: 14 January 2022 |
| 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 |
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|  | 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 |
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| 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

Murray Halberg is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia, and hospital level care for up to 160 residents. There were 116 residents at the time of the audit.

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

The village manager is appropriately qualified and experienced and is supported by a regional manager, a resident services manager, and a clinical manager/registered nurse. A unit coordinator is employed for each level of care (hospital, rest home, dementia, and serviced apartments). There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

The one shortfall identified at the previous certification audit around documenting resident interventions has been met.

This audit did not identify any shortfalls.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and family interviewed verified ongoing involvement with the community

Organisational management

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| 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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The service is owned and operated by Ryman. A business plan drives service improvement. The village manager has a background in business consultancy and the clinical leader is a registered nurse with a current practising certificate who has been working in the aged care area for over five years. There is a unit coordinator for each level of care (rest home, hospital, dementia) and for the serviced apartments.

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored. There is a high level of satisfaction from residents and relatives.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Appropriate employment processes are adhered to. An education and training programme is established. The roster provides sufficient and appropriate staff cover for the effective delivery of care and support for all residents.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |
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The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

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

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

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

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

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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The building has a current building warrant of fitness (BWOFF) and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place.

Restraint minimisation and safe practice

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

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme includes policies, standards, and procedures to guide staff. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (unit coordinator/RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking with other Ryman facilities. There has been one outbreak since the previous audit which was appropriately managed.

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) |
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| Standards | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 41 | 0 | 0 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <p>The service has a complaints policy that describes the management of the complaints process. Feedback forms are available. Information about complaints is provided on admission and on noticeboards. Interviews with residents and family members confirmed their understanding of the complaints process. Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction.</p> <p>The village manager, clinical manager supporting the service, and the resident services manager were interviewed during the audit. Staff were interviewed on the day of audit (five caregivers, five registered nurses, three-unit coordinators (dementia, serviced apartments, hospital), three activity coordinators and one chef. Staff interviewed were able to describe the process around reporting complaints. All stated that complaints were important to improve services.</p> <p>A complaint register is in place. Six complaints were received in 2021. There have not been any complaints in 2022 year to date. Four complaints were reviewed during the audit. All were investigated and resolved within timeframes determined by the Health and Disability Commission (HDC). There is evidence of the themes of the complaints being discussed in staff and management meetings with appropriate follow-up actions taken.</p> <p>There were no complaints lodged by external providers since the last audit.</p> |

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| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Thirteen adverse events reviewed confirmed that family were notified when an incident occurred in a timely manner. Five family members interviewed (four with family in the dementia unit and one in the hospital) confirmed they have been notified following a change of health status of their family member. Family also confirmed that they had been informed around changes in visiting requirements as a result of the Covid 19 pandemic. All stated that the service had provided timely information around the pandemic.</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p> <p>Five residents were interviewed (three under a rest home level of care and two requiring hospital level of care). All residents stated that staff have provided 'excellent' information around Covid 19 and they stated that there was always good communication. They confirmed that there was an open door to the managers, and they could discuss their concerns or requests at any time.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The Murray Halberg Retirement Village is a Ryman Healthcare facility located in Lynfield, Auckland. There are 160 beds certified to provide care and support. There are 38 dementia beds across two separate secure units (with a shared nursing station), and two 46-bed rest home/hospital (dual purpose) units. Thirty serviced apartments across three levels are certified to provide rest home level care. Of those 30 serviced apartments, nine of the apartments adjacent to the hospital/rest home on level three are also certified as suitable to provide hospital level care.</p> <p>Occupancy on the day of audit was at 116. This included 30 residents in the secure dementia unit; 44 at rest home level of care with four residents in serviced apartments and all others on level two (two of whom were requiring respite level of care). There were 42 residents requiring hospital level of care including four in serviced apartments with the rest on level three. Four residents requiring hospital level of care are under a respite contract. All other residents are under an Age Residential Related contract.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually, specific to Murray Halberg. Each objective includes an action place and person(s) responsible. There are specific projects with action plans related to clinical, health and safety, human resources, and resident/relative feedback. Details of progress are reported quarterly.</p> <p>The village manager at Murray Halberg has a business consultancy including cultural and organisational change and marketing background. They started in in December 2018. They are supported by a resident services manager, a clinical manager, and the national clinical manager. The clinical manager is currently on leave overseas with the return date scheduled for the 29 January 2022. They have been working in aged care for over five years. The service is being supported by a clinical manager of a neighbouring service. a regional manager</p> |

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| | | <p>and a regional quality manager. There are four coordinators who are responsible for overseeing and leading their units. There are four units: hospital, rest home, dementia, and serviced apartments. All are registered nurses. The unit coordinator in the dementia unit is a comprehensive trained nurse.</p> <p>The managers have maintained more than eight hours annually of professional development related to managing an aged care service.</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>A quality and risk management system that is directed by head office (Ryman Christchurch) is established and implemented. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. The village manager reports to the regional operations manager with two weekly face to face meetings. Monthly reports are submitted and discussed with the summary of progress against the business plan posted in the staff room. There are also weekly zoom meetings for village managers in each region and these include sharing of information and discussion of new initiatives. Discussions with managers and staff, and the review of meeting minutes demonstrated the collective involvement of managers and staff in quality and risk management activities.</p> <p>Resident meetings are held two-monthly for each service level and relative meetings are scheduled six-monthly. The village manager attends the meetings, and minutes are maintained. Resident and relative surveys are completed annually. The relatives survey was completed last in August 2021. The service had the highest net promotion score (NPS) of any Ryman village. The NPS was 74 with the service ranking moving from 19th to number 1. The level of detractors decreased significantly from 2020 to the 2021 survey. The resident satisfaction survey was completed in April 2021. The overall scores for hospital and rest home residents were combined to give a NPS of 23 ranking the service as 30 out of 42 villages. The lowest score was for food and a corrective action plan is in place to improve food services. This was the first survey for residents and the service was not able to compare results with last year (2020).</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service-appropriate management systems, policies, and procedures are developed, implemented, and regularly reviewed, meeting sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being</p> |

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| | | <p>implemented and signed off when completed. Meetings include monthly management, team Ryman management, clinical, activities and health and safety. Other meetings held two or three monthly include infection control, caregiver, kitchen/food services and gardening and maintenance. Restraint approval meetings along with housekeeping/laundry, night duty staff and administration meetings are held six-monthly. The internal audit programme is followed as per the schedule. A quality improvement plan (QIP) is initiated when audits show that there are corrective actions required. Resolution was achieved in a timely manner.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. Health and safety data is tabled at staff and management meetings. A review of the risk register and the maintenance register indicated that there is resolution of issues identified. All new staff and contractors are inducted to health and safety processes. There is also annual in-service training and competency assessments.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls with a range of examples provided (e.g. providing falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; routine checks of all residents specific to each resident's needs (intentional rounding); the use of sensor mats and night lights; and increased staff awareness of residents who are at risk of falling). Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and identifying those residents who were at risk.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise, and debriefing. Individual incident reports are completed electronically using VCare for each incident/accident with immediate action(s) and any follow-up action required evidenced.</p> <p>A review of 13 incident/accident reports (including unwitnessed falls, two pressure injuries and challenging behaviours) included follow-up by a registered nurse. All incident forms that involved a resident with an unwitnessed fall had neurological observations taken as per policy.</p> <p>The managers and unit coordinators are involved in the adverse event process via regular management meetings and informal meetings during the week that provide an opportunity to review any incidents as they occur. The village manager and clinical manager were able to identify situations would be reported to statutory authorities. There were 17 pressure injuries reported to HealthCERT on a Section 31 in 2021 and one reported in 2022 year to date. There is a QIP looking at pressure injuries. There was one outbreak in 2021 with this reported to appropriate authorities.</p> |

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| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. Eight staff files were randomly selected for review (two registered nurses, two caregivers, one clinical manager, two-unit coordinators, one activities coordinator). Each file included an application form and two reference checks, a signed employment contract, job description, police check, and completed orientation programme. All files reviewed also included a six-monthly performance appraisal.</p> <p>A register of registered nurses current practising certificates is held on site. Practising certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. The general orientation programme that is attended by all staff covers Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. Staff also complete annual competency questionnaires. RNs are supported to maintain their professional competency. Five of thirteen RNs have completed their interRAI training. RNs attend journal club. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>There are 50 caregivers employed in the service (including full and part time staff). Two have completed level two NZQA certificates; 41 have completed level three; and 18 have completed level 4. There is one with a level 7 qualification. There are 17 caregivers working in the dementia unit; Seven have completed training in dementia, eight are in training and two are new to the unit (less than four months since employment).</p> <p>There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including (but not limited to) medication competencies and insulin competencies.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</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, resident services manager, and clinical manager work Monday – Friday.</p> <p>Four-unit coordinators with a total of 42 residents requiring hospital level of care including three in serviced apartments at hospital level of care.</p> <p>Level two Rome wing (occupancy of 44 residents at rest home level of care including four residents using respite</p> |

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| <p>and/or experienced service providers.</p> | | <p>care and four in serviced apartments). Staffing is as follows: AM (morning): three caregivers including two long shift and one short shift; PM (afternoon): three caregivers including two long shift and one short shift; three caregivers overnight all on a long shift. There is one registered nurse rostered to work on the morning shift seven days a week and the unit coordinator works from Sunday to Thursday.</p> <p>Level three Perth wing (occupancy of 42 residents at hospital level of care including two residents using respite care and three in serviced apartments on the same floor). Staffing is as follows: AM (morning): nine caregivers including four long shift and five short shifts; PM (afternoon): eight caregivers including two long shift, five short shift and one lounge assistant; three caregivers overnight all on a long shift. There are two registered nurses rostered to work on the morning and afternoon shifts seven days a week and one overnight. The unit coordinator works from Sunday to Thursday.</p> <p>Cardiff (the dementia) unit is split into two wings (A with 14 residents and B with 16 residents) with a shared nursing station. Staffing is as follows: AM (morning): six caregivers including one lounge caregiver; PM (afternoon): five caregivers including two long shift and three short shifts; two caregivers overnight. In addition to a unit coordinator/RN five days a week (Tuesday to Saturday), there is a registered nurse who works rostered to work seven days a week (AM shift).</p> <p>There are two caregivers to support residents in the serviced apartments in the morning and two in the afternoon (one long shift and ne shirt shift in the morning and afternoon). Hospital staff respond to any call bells after 9PM. The call system is linked to the RN pagers.</p> <p>A 'cover pool' of staff are additional staff that are rostered to cover staff absences.</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 the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p> |
| <p>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</p> | <p>FA</p> | <p>Fourteen medication files were reviewed on the electronic medication management system.</p> <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised medication blister packs for regular and 'as needed' (PRN) medications. Medication reconciliation is completed, and all regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. A bulk supply order is maintained for hospital level residents.</p> <p>Medications are stored safely in all units (hospital, rest home, serviced apartments, and dementia care units). All</p> |

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| <p>guidelines.</p> | | <p>medications were within the expiry dates. Eye drops and ointments are dated on opening. Medications are managed appropriately in line with required guidelines and legislation. Medication fridge and room temperature monitoring is undertaken with evidence of all temperatures being within the required range. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role regarding medicine administration.</p> <p>There were no residents self-medicating on the day of audit, standing orders are not used and no vaccines are stored on site</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The meals at Ryman Murray Halberg are all prepared and cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence which expires 5 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. The senior lead chef (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Food is delivered from the main kitchen to all areas in scan boxes and served by care staff in each wing's servery. 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 service has started an initiative where they can adapt the menu for an increasing number of Indian residents and have plans to develop this further. The residents interviewed were very satisfied with the standard of food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p> | <p>FA</p> | <p>Family interviewed expressed satisfaction with the level of care provide and this was also evidenced in current net promoter scores. The nurse practitioner also expressed satisfaction with the care received by residents and the service in general. Registered nurses and caregivers report progress against the care plan at least daily. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the district nurse/GNS). If external medical advice is required, this will be actioned by the GP/NP. Communication with family is</p> |

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| <p>order to meet their assessed needs and desired outcomes.</p> | | <p>documented in progress notes and on the family communication sheet.</p> <p>Care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given). Monitoring charts are well utilised. Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Contenance products are available and resident records include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the registered nurse. Care plans documented the continence care and support required for each resident and continence products were available according to the continence plan.</p> <p>Monthly weighs have been completed in all long-term files sampled. Referral to dietitian occurs as required, as confirmed in sampled files.</p> <p>Wound assessment, wound management plans and monitoring were in place for all identified wounds. This included 67 wounds in total, comprised of thirty-five skin tears, one abrasion, eight lesions, six chronic ulcers, sixteen pressure injuries and one classified as 'other' (dermatitis etc). There were sixteen pressure injuries (same residents with multiple) at the time of audit which show appropriate management, review, and documentation. All wounds have been reviewed in appropriate timeframes and specialised wound management advice through the district nursing service, DHB GNS and Ryman wound champion was in evidence where required. Dressing supplies are available, and the treatment rooms are stocked for use. Staff receive regular education on wound management.</p> <p>InterRAI assessments tools are used for any change in health condition and to develop the ongoing care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record. Evidence was sighted for speech language therapist, physiotherapist, dietitian, hospice, podiatrist, mental health services and wound care specialist (DHB virtual wound clinic). There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed.</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), wound or recent fall. Falls protocols and neurological observations were evidenced for all unwitnessed falls. The shortfall in this area identified at the previous audit has been fully satisfied.</p> |
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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>There are eleven activity and lifestyle coordinators and assistants who provide a separate Monday to Friday activity programme for the rest home, and seven-day programme for hospital and dementia care units. There are separate activities available for the serviced apartment residents. A company diversional therapist (DT) oversees the activity programmes. The activity coordinators attend Ryman workshops and on-site in-services. The three activities coordinators interviewed on day of audit were working towards their DT qualifications. All hold current first aid certificates.</p> <p>An activity plan is developed from an initial assessment of the resident's likes, dislikes, and abilities. This is then detailed in the resident care plan and the resident is encouraged to join in activities that are appropriate and meaningful. The activity plan is reviewed six-monthly in line with all other aspects of the resident's care plan unless a change in abilities necessitates an earlier review. A resident attendance list is maintained for activities, entertainment, and outings.</p> <p>The programme is planned monthly and includes Ryman minimum requirements for the "Engage" activities programme. Activities programmes are displayed on noticeboards around the facility and a monthly calendar is delivered to each individual resident. There is a core programme, which includes the triple A (Active, Ageless, Awareness) exercise programme. Activities are delivered to meet the cognitive, physical, intellectual, and emotional needs of the residents. One-on-one time is spent with residents who are unable to actively participate in the activities.</p> <p>A variety of individual and small group activities were observed occurring in the rest home, hospital, and dementia care units at various times throughout the days of audit. Residents in serviced apartments can choose to attend the serviced apartment or rest home/hospital activities. Entertainment and outing are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed.</p> <p>Activities in the dementia care units were observed during audit. Activities staff provided a stimulating, inclusive and enjoyable programme. Most of the residents from both units were observed participating and enjoying the exercises and music events on the day. Activities include triple A exercises, singing, happy hours, hand therapy, word games, art, crafts, and dancing.</p> <p>Resident meetings are held two monthly and family meetings six monthly. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents interviewed spoke positively about the activity programme provided.</p> |
| <p>Standard 1.3.8: Evaluation</p> | <p>FA</p> | <p>The evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Five</p> |

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| <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | | <p>long-term care files sampled of permanent residents (excludes a recent admission and one respite) contained written evaluations completed six-monthly. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP/NP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>The facility has three service levels across five floors (including serviced apartments). All care beds (dementia excluded) are dual purpose; however, the service currently runs level 1 - dementia, level 2 - rest home and level 3 - hospital. Serviced apartments are across levels 3, 4 and 5. Level 1 consists of two 19-bed dementia units sharing a central nurse's station. Any serviced apartment can be utilised for rest home level care (up to a maximum of 30) and nine of the 30 apartments on level three are certified for hospital level care. 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 current building warrant of fitness (BWOFF) which expires 6 August 2022. 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 October 2022. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise safely using mobility aids.</p> <p>Residents were observed safely accessing the outdoor gardens and courtyards. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The secure dementia care units each include an open plan dining/lounge area. Each unit has access to two external areas with walking pathways, raised gardens, seating and shade.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have</p> | <p>FA</p> | <p>The surveillance programme is organised and promoted via the Ryman calendar. Effective monitoring is the responsibility of the infection prevention and control officer who is a unit coordinator (RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the clinical meeting, weekly management meeting, infection prevention and control (IPC) meetings and full staff meetings.</p> <p>Six-monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Ryman Murray Halberg include discussion on infection prevention control. The IPC programme is</p> |

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| <p>been specified in the infection control programme.</p> | | <p>incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and are analysed at site level using power BI.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and all staff have received both doses of the Pfizer Covid-19 vaccine. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of N95 face masks is required as part of orange alert level restrictions.</p> <p>There has been one gastro outbreak in July 2021 which was appropriately managed with public health unit input.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Restraint practices are 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>The hospital unit coordinator is the restraint coordinator. The interview with the restraint coordinator confirmed their knowledge around both restraints and enablers. During the audit, there were no residents using any restraints or enablers.</p> <p>Staff training including staff competencies are implemented addressing restraint minimisation and enablers, falls prevention and analysis, and the management of challenging behaviours. This begins during their induction to the service and continues annually. There are also small group sessions held to discuss specific resident behaviour.</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.

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

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End of the report.