

Julia Wallace Retirement Village Limited - Julia Wallace Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Julia Wallace Retirement Village Limited
Premises audited:	Julia Wallace 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: 1 February 2022 End date: 2 February 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:	85



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

Ryman Julia Wallace provides rest home, hospital, and dementia level of care for up to 104 residents. There were 85 residents at the time of the audit that included 80 residents in the care centre and 5 rest home level 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, interviews with residents, family, management, staff, and a nurse practitioner.

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

One improvement is required in relation to health and safety.

There are three areas of continuous improvement awarded around good practice, restraint minimisation and infection control.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are 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 and implemented Māori health plan in place. Individual care plans reflect 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 when a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

Informed consent procedures and advance directives are discussed with residents on admission. There is an established system that is being implemented for the management of complaints.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

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

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

Registered nursing cover is provided on-site seven days a week with additional on call cover 24/7. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service. InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner/nurse practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme which is varied and interesting. The engage programme meets the abilities and recreational needs of the group of residents including a men's group.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and medication-specific education. The general practitioner/nurse practitioner reviews medications three-monthly.

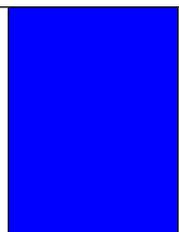
The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food that is provided.

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.
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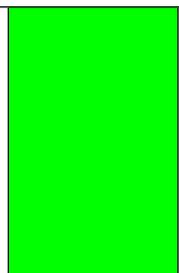
The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with full ensuites. There are adequate numbers of communal toilets. There was sufficient space to allow the safe movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. 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.

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.
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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. At the time of the audit there were no residents using restraint and four residents using enablers. Staff receive regular education and training in relation to restraint minimisation and managing challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. There has been additional focus and education on infection control and change to some policies since the covid outbreak. A six-monthly comparative summary is completed. The service has had two outbreaks since the last audit that were well-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)
Standards	2	42	0	1	0	0	0
Criteria	3	89	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one village manager, one clinical manager, and one operations quality manager) and eighteen staff interviewed (one assistant manager, four unit coordinators (one hospital/registered nurse (RN), one rest home/RN, one dementia/RN, one serviced apartment/enrolled nurse (EN)), three registered nurses (RNs), five caregivers (one covers the dementia unit, two hospital, one serviced apartments and one rest home), two activities staff, one maintenance, one cleaner, one laundry) were able to describe how the Code is incorporated into their day to day responsibilities. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents form part of the admission agreement as sighted for 11 resident’s files reviewed. There are specific written consents for procedures including wound photographs, influenza/covid vaccines and indwelling catheters.</p> <p>Advanced directives are signed for separately. Copies of enduring power of attorney (EPOA) are kept on the residents file where required. The EPOAs had been activated in the three dementia care resident files reviewed. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when</p>

<p>information they need to make informed choices and give informed consent.</p>		<p>delivering care Discussions with family members confirmed that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten of eleven resident files reviewed have signed admission agreements, ongoing efforts were being made to have the eleventh signed.</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>	<p>FA</p>	<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/EPOA to be involved in decisions. The residents' files include information on residents' 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>	<p>FA</p>	<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 as covid restrictions allow. 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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in visible locations around the facility. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. They reported that they would feel comfortable addressing a concern with the village manager and/or clinical manager. Staff interviewed were able to describe the process around reporting complaints.</p> <p>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. Six complaints received in 2021 have been managed in a timely manner and are documented as resolved. No complaints have been lodged with HDC or the DHB since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code with residents and families during the admission process. Five relatives (two hospital and three dementia) and five residents (two rest home with one in a serviced apartment and three hospital) 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 in English and te reo Māori. The managers 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. This is included in the service agreement.</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>	<p>FA</p>	<p>Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being done. All residents' rooms are single rooms with their own private ensuite.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident 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 residents' cares. Staff attend education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Ryman has an organisational Māori health plan that is being implemented at Ryman Julia Wallace. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with a kaumatua who blesses the facility every year with the most recent blessing occurring on 13 December 2021. Links are also established with other Māori community representative groups as requested by the resident/family. Staff receive cultural training which is initiated during their orientation and is repeated every year.</p> <p>One resident who identifies as Māori was living at the facility (hospital) but was unable to be interviewed and whanau were not available. This residents file was reviewed. A Māori health plan was completed on admission with links to the resident's care plan. The care plan/cultural needs are reviewed six-monthly. Family/whānau involvement in assessment and care planning and visiting is encouraged with evidence of whanau signing this particular resident's Māori health plan.</p>
<p>Standard 1.1.6:</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are</p>

<p>Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>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 is invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents and relatives interviewed confirmed that staff take into account their cultural values where identified.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provides guidelines and mentoring for specific situations. Interviews with staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>All Ryman facilities have an electronic 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.</p> <p>A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (head office) for collating, monitoring, and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. These QIPs are then signed off when implemented. 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. Falls and challenging behaviours for the facility remain low, below the Ryman average. Another highlight of good practice for this facility are the low rates of bruising.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the district health board which includes visits from specialists. A physiotherapist is available 12 hours per week with additional support provided by a physiotherapy assistant although this position was vacant at the time of the audit.</p> <p>There is a robust education and training programme for staff that includes in-service training, online training</p>

		<p>and annual competency assessments that monitor staff comprehension across a range of topics. RNs attend a journal club meeting every two months. Podiatry services and hairdressing services are provided. The service has established links with the local community and encourages residents to remain independent. The facility has maintained a Covid-free environment. Other examples of good practice include maintaining a homely environment, increasing staff attendance at educational in-services, reducing the number of complaints through building relationships with families, improving the quality of food as evidenced in the resident satisfaction surveys and completing a total overhaul of the gardens.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arises. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Fifteen incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.</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>	FA	<p>Julia Wallace is a Ryman Healthcare retirement village located in Palmerston North. They are certified to provide rest home, hospital, and dementia levels of care in their care centre for up to 84 residents. There are also 20 serviced apartments that are certified to provide rest home level care. Sixty-three beds in the care centre are certified as dual-purpose beds and twenty-one beds are available in the special care unit for dementia level of care.</p> <p>At the time of the audit, occupancy in the care centre was 30 rest home, 30 hospital and 20 dementia level residents. In addition, there were five rest home level residents in the serviced apartments. The hospital level of care is certified for geriatric and medical. There were four residents on respite (one rest home, one dementia, two hospital), one on ACC (hospital), and two on the long-term support – chronic health care contract (LTS-CHC) (hospital). All remaining residents were on the age-related residential care (ARRC) contract.</p>

		<p>There is a documented service philosophy that guides quality improvement and risk management. Annual objectives are defined with evidence of regular reviews and quarterly reporting to senior managers on progress towards meeting these objectives. Staff are kept informed of progress in the full facility meetings.</p> <p>The village manager has been in her role at this facility for the past 12 months. She has 37 years of experience in the health sector and trained in 1983 as an enrolled nurse. She no longer has a current practising certification. The village manager is supported by a regional manager, an operations quality manager, an assistant manager, and a clinical manager/RN. The village manager and clinical manager have attended a minimum of eight hours of professional development per year relating 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 of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager and assistant manager are responsible during the temporary absence of the village manager, with added support provided by the regional manager and Christchurch Ryman team.</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>	PA Low	<p>Ryman Julia Wallace has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff, and review of meeting minutes reflects their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly. Minutes are maintained. Annual resident and relative surveys are completed with the last survey completed in February 2021. Results are benchmarked against all Ryman facilities. The sample size for the 2021 survey was very small (six residents). Residents who did complete a survey were either satisfied or very satisfied with their care, with improvements in scores noted when comparing 2021 results to 2020 (care, communication, linen, food, activities, building grounds). Strategies are being implemented to improve the return rate of responses for 2022, which is scheduled for this month (February 2022).</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national</p>

		<p>level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and service delivery. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented, and regularly reviewed for the sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and identify trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>The Health & Safety Committee meets monthly and consists of the management team, restraint officer, infection control officer, Health and Safety Officer, Fire Officer & Head of maintenance and Head of Gardening conduct regular evaluation of work schedules, processes, and the working environment. Hazard identification and risk analysis has been carried out on tasks and activities at the village. Hazard registers detail the risk and how each risk is mitigated and controlled. These are reviewed annually. Contractors sign into the village using an electronic sign in process and they have submitted all relevant safety documentation. Contractors are also orientated to health and safety although, during the audit a near miss event observed has resulted in a shortfall.</p> <p>Health and safety policies are implemented and monitored. One health and safety representative (maintenance) was interviewed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Health and safety training begins during a new employee's induction and continues a minimum of annually.</p> <p>A range of falls prevention strategies include (but are not limited to) falls risk assessments; education for staff, physiotherapy assessments for all new residents and for residents who have either fallen or are at a high risk of falling; use of appropriate footwear; increased supervision and monitoring for at-risk residents, and sensor mats if required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>A review of a sample of 15 adverse events (witnessed and unwitnessed falls, skin tears) identified that all forms were fully completed and included follow up by a registered nurse. The clinical manager is involved in reviewing each adverse event, with links to meeting minutes. This provides the opportunity to review any incidents as they occur. Neurological observations are completed if there is a suspected injury to the head or following an unwitnessed fall.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities with examples provided. Section 31 reports were completed in 2021 for a change in management, grade three or unstageable pressure injuries (seven) and one instance of a resident assault with police involvement. Both public health and the DHB were notified of the outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Twelve staff files reviewed (one chef, two unit-coordinators, two staff RNs, one diversional therapist and six caregivers) included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in and completed induction checklists. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates is maintained within the facility. Practising certificates for other health practitioners were sighted to provide evidence of their current registration.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position in addition to a more general orientation.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Journal club meetings are provided two-monthly. Online training and competency assessments are included in the training programme.</p> <p>Thirteen of sixteen registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Twenty-one of twenty-two caregivers who work in the dementia unit have completed their dementia qualification. The remaining caregiver has been employed for less than one year in the dementia unit and is enrolled in this programme. In total (fifty-six caregivers), five have completed a level two qualification, four have completed a level three qualification and six have completed a level four qualification. Two caregivers have a level seven (diploma in health services) qualification.</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.</p> <p>The facility covers two floors with an elevator and stairs for access. The clinical manager is an experienced registered nurse with a current practising certificate who works full time Tuesday-Saturday. She is supported by four unit-coordinators (three RNs (rest home, dementia, hospital) and one enrolled nurse (serviced apartments) who stagger a seven day a week schedule.</p> <p>There are twenty serviced apartments certified to provide rest home level of care that span two floors with five rest home level residents during the audit. The serviced apartment unit coordinator (EN) or a senior caregiver cover seven days a week and are supported by two caregivers on the AM shift (one long and one short shift) and two caregivers on the PM shift (short shift only). The rest home caregivers cover the serviced apartments after 10 pm and through the night shift. Staff communicate via mobile telecommunications.</p> <p>The rest home wing (27 residents) is located on the ground floor. Staffing includes a rest home coordinator/RN (Tues – Sat) and a senior caregiver on Sunday/Monday. Two long (eight hour) shift caregivers and one short shift (to 1300) caregivers cover the AM shift, two long and one short shift (1630-1830) dining assistant) cover the PM shift and two caregivers cover the night shift.</p> <p>The hospital wing (three rest home and thirty hospital level residents), also on the ground floor, is staffed with a unit coordinator/RN (Sun - Thurs). This is in addition to two staff RNs who are assigned on the AM and PM shifts. Four long shift and two short shift (to 1330) caregivers cover the AM shift, two long and two short shift (to 2100) cover the PM shift and two caregivers cover the night shift.</p> <p>The first level includes the secure dementia unit (20 residents). The dementia unit is staffed with a unit coordinator (RN) from Tues – Sat and an RN on Sunday and Monday. There are two caregivers who work the AM shift (long shifts), and three caregivers who cover the PM shift (two long and one short shift/lounge carer). Two caregivers cover the night shift.</p> <p>A cover pool (32 RN hours and 64 caregiver hours per fortnight) has been implemented whereby (extra) care staff are scheduled to help cover absences. Separate cleaning and laundry staff are rostered.</p> <p>Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<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. Information containing</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration. All resident files are documented electronically and therefore are legible, dated and include the name and designation of the relevant caregiver or RN. All electronic data is individually password protected.</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>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The welcome pack also includes information specific to dementia level of care.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term care. Clear processes exist that support older people and their families to understand what the payments are for.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has 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 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 policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation is undertaken by two RNs. Any errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all units. Medication fridges and treatment room temperatures are monitored daily- treatment rooms had been fitted with air conditioning units.</p> <p>Four self-medicating residents (one rest home and three hospital) had been assessed and reviewed by the GP and RN as competent to self-administer their inhalers and vitamin supplement.</p>

		<p>Twenty-one charts (seven hospital, eight rest home- including one resident in apartment wing - and six dementia care) medication charts were reviewed on the electronic medication system. Medication charts had photo identification, allergy status and had been reviewed three-monthly by the GP/NP. All medication charts reviewed have 'as needed' medications prescribed with an indication for use. The effectiveness of 'as required' medications is entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by two additional chefs so there is a chef onsite 8am to 7pm daily, two cook's assistants and five kitchenhands. Staff have been trained in food safety. Menu choices are ordered by residents (or staff if the resident is not able) the week before.</p> <p>The four-weekly seasonal menu offers several meal choices including a vegetarian option. The menu choices accommodate resident dislikes and gluten free diets. The seasonal menu has been designed in consultation with the dietitian and regional chef at an organisational level. Meals are delivered in hot boxes (with the exception of the rest home which is directly adjacent to the main kitchen) and served from bain-maries in each unit.</p> <p>Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours in the dementia care unit.</p> <p>Freezer and chiller temperatures, end cooked and serving temperatures are taken and recorded daily. The chilled goods temperature is checked on delivery. All foods were date labelled. Decanted dry goods had expiry dates. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings, twice weekly electronic food satisfaction surveys, annual 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</p>	FA	<p>The service records the reason for declining service entry to 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>

appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that were triggered reflected appropriate interventions in the care plans reviewed. A suite of assessments are available on the myRyman system to the RNs to utilise as appropriate. assessments sighted, (but not limited to) include behavioural, wound and restraints were completed according to need. In the resident files reviewed the outcomes of all assessments, needs, and supports required were reflected in the care plans.</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>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans were resident centred and support needs and interventions were documented in detail to reflect the outcomes of clinical assessments. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. Residents and family stated they were involved in the care planning and review process.</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>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. Care plans are updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections.</p> <p>Electronic wound assessments, treatment plans and evaluations were in place for 14 residents with wounds (skin tears, a surgical wound and six chronic ulcers). There were no pressure injuries. Adequate dressing supplies were sighted in the treatment rooms. The wound care champion (registered nurse) for the service provides advice and support to RNs and reviews wounds weekly. She has access to the DHB wound nurse as required.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RN's interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight; blood pressure and pulse; neurological observations post unwitnessed falls or identified head injuries; food and fluid charts; restraint monitoring; pain monitoring; blood sugar levels; and behaviour charts. Progress notes document changes in health and significant events.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of three activities coordinators (two diversional therapists, one an enrolled nurse) to deliver the engage programme across the rest home, hospital, dementia care unit and serviced apartments. Activity coordinators attend on-site and organisational in-service relevant to their roles. All have current first aid certificates.</p> <p>The engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group. Rest home residents in the serviced apartments attend either the serviced apartment or rest home programme. The engage programme is seven days a week in the hospital and dementia care units and Monday to Friday in the rest home and serviced apartments. Lounge carers on the afternoon in the hospital support the DT with activities. There are plentiful resources available. Residents receive programmes in their rooms as appropriate. Daily contact is made with residents who choose not to be involved in the activity programme. One-on-one time is spent with residents unable to participate in group activities. Triple A exercises occurs daily in each unit to meet the physical and cognitive abilities of the residents. There are regular supervised walks outside. There are many activities that are open to all residents including: entertainment; mass picnics; village spelling bee; quizzes; children's party (off-site); and men's group however at present with Covid restrictions some have been postponed or modified. There are regular van outings for shopping, visits to cafes and places of interest. Residents are encouraged to maintain links with the community and for community visitors to come to the home however these are currently limited.</p> <p>Weekly interdenominational church services are held on-site in the chapel (postponed at present) and monthly in the dementia care unit.</p> <p>On observation and/or interview the younger persons in the home were given a full choice of what they would like to do (in the facility or in the community – covid restrictions permitting). On interview one resident stated how excellent the staff were at always having her ready on time to go out to usually a large number of community activities. Another who chose to just go on the regular weekly outing was well set up to undertake activities she wished to do e.g. painting and reading.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>Eight of eleven care plans had been evaluated six-monthly by registered nurses. Two residents (one hospital and one rest home care) had not been at the service six months and one hospital resident was on respite). Written evaluations describe the resident's progress against the resident's identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals such as the physio involved in the care of the resident. The family are notified of the outcome of</p>

manner.		the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP/NP visits.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Referral to other health and disability services is evident in the resident files reviewed. 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 services.
<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>	FA	There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets and product use information was readily available. Staff have attended chemical safety training.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities</p>	FA	<p>The building has a current building warrant of fitness that expires 9 December 2022. The facility has two levels with the care centre (rest home and hospital) on the ground level and dementia care unit and serviced apartments on the first floor. There is lift and stair access between the levels.</p> <p>The maintenance person ensures daily maintenance requests are addressed. He maintains a 12-monthly planned maintenance schedule which has been signed off monthly as completed. Essential contractors are available 24 hours. Electrical testing is completed annually (July 21). Annual calibration and functional checks</p>

<p>that are fit for their purpose.</p>		<p>of medical equipment is completed (June 2021) by an external contractor.</p> <p>Hot water temperatures in resident areas are monitored as part of the three-monthly environmental audit. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens, atrium, and courtyards safely. Seating and shade are provided.</p> <p>The dementia care unit is secure and has an internal walking area and residents have access to a safe outdoor deck with seating and shade. There is an open conservatory area has been off the lounge. The conservatory provides another area for outdoor activities. (link 1.2.3.9)</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>	<p>FA</p>	<p>All bedrooms are single occupancy and have full ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and</p>	<p>FA</p>	<p>All resident's rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids and hoists. Residents are encouraged to personalise their bedrooms as viewed during the audit.</p>

setting.		
<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 rest home unit and hospital unit each have a separate lounge area and dining room. There are seating alcoves, a library room, and a family room within the care centre. Both units have an internal courtyard. The large main lounges have seating placed to allow for individual or group activities. There is a hairdresser, shop, and chapel/reflection room available to all residents. The dementia unit has a spacious combined dining room and lounge area.</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 Ryman group has documented systems for monitoring the effectiveness and compliance of 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. The chemical provider monitors the effectiveness of chemicals and provides training.</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. Emergency management, first aid and CPR are included in the mandatory education programme. There is a minimum of one first aid trained staff member on every shift and on outings. The village has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities are in place. There is a civil defence kit in the facility and ample water storage on-site. A diesel-powered generator is available in the event of a power outage.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. The call bell system is linked to staff pagers and to the call bell panels in the rest home. Residents can choose to wear an alarm pendant. Maintenance regularly checks the call bell system.</p> <p>Staff confirmed that they conduct security checks at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And</p>	FA	<p>General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight. Internal ground floor rooms open out onto the atrium.</p>

<p>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>		
<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 clinical manager (CM) is the infection control coordinator and leads the committee consisting of the village manager, assistant, and all unit coordinators. The CM has a job description that outlines IC responsibilities. The clinical and facility meetings receive a report on infection prevention and control matters at their monthly meetings. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and a six-month analysis is completed and reported to the governing body.</p> <p>Visitors are asked not to visit if they are unwell and at present must book an appointment to visit and comply with covid requirements e.g., check in, have their temperature recorded and wear a mask and face shield. Residents are offered the covid vaccination and annual influenza vaccine. There are adequate hand sanitizers and personal protective equipment throughout 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 control coordinator has received training (March & May 2021) and is currently enrolled to undertake a Postgraduate certificate in Infection Control. The infection control coordinator also links into ARCC managers forums at the DHB. The DHB has provided some equipment for the covid period and this is supplemented by Ryman. The facility also has access to an infection prevention and control nurse specialist from the DHB and expertise within the organisation, public health, GPs, local laboratory, and external infection control consultant. There is also support from other clinical managers within Ryman. On audit it was evident that changes in staffing and management had also been made to minimise any spread of covid within the facility and to other facilities, e.g. staff were now working in bubbles, only working at Julia Wallace, changing of uniforms between units, not leaving the department for breaks, and strict control for laundry and kitchen teams. There was a declaration/sign in process including the taking of temperatures. Security was implemented to screen all people coming to site.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	FA	<p>There were comprehensive infection prevention and control policies that were 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 are reviewed and overseen by the infection control specialist at head</p>

<p>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>		<p>office. The infection prevention and control policies link to other documentation and cross reference where appropriate. Benchmarking occurs with other Ryman facilities.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions. All staff complete annual hand hygiene and use of PPE competencies. At present monthly covid drills are being held to be familiar with how one would manage a case of covid, the fitting of a mask and other matters relating to prevention and/or management of an outbreak. Infection control is an agenda item on the full facility and clinical meeting agenda. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p> <p>Over the period of covid, education on infection control has been increased to monthly with nationally recognised infection control specialists involved.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control coordinator completes a monthly report. Monthly data is reported to the infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility and also electronically. The infection prevention and control programme links with the quality programme. The infection prevention and control coordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GP/NPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. A significant reduction in the rate of urinary tract infections has resulted in a rating of continuous improvement.</p> <p>There was a norovirus outbreak July 2021 and a respiratory outbreak in February 2020. Public Health was</p>

		notified in both instances.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	CI	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit, the facility had not used any restraints since October 2020. Lazy boy chairs are regularly used for positioning residents but not for the purpose of restraining residents. Four residents (hospital) were using bedrails as enablers.</p> <p>Restraint policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. Staff training is provided around maintaining a restraint-free environment as well as strategies to manage challenging behaviours and minimise falls. This training includes online learning, and competency assessments that are repeated each year.</p> <p>Four of four files of residents using enablers were reviewed. Assessments for the use of enablers were sighted and included risks associated with using bedrails. All four residents had provided written consent for the use of the bedrails and use of the enablers were linked to their care plans. This process is reviewed six-monthly with input from the nurse practitioner.</p> <p>The facility has received a rating of continuous improvement in relation to maintaining a restraint-free environment for over one year.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change</p>	PA Low	A hazardous area in the dementia unit was accessed by a resident and was observed as a near miss event.	During the audit, while the auditor was observing in the special care (dementia) unit, the outdoor area was unattended. This area was being painted by an external contractor. During this observation, the area was unattended, not cordoned off, paint was left in a pan on the ground and a long-handled paint brush was left splayed across the ground (note the outdoor area is a narrow space). During this time, a resident was observed to open the door, go outside, and was observed to bend down and inspect the paint that was on the ground. After a few minutes, the caregiver saw what was happening and went outside to coax the resident back into the facility. This area remained a hazardous area and the door remained unlocked (key access only) despite this occurrence. The unit coordinator was unavailable on the phone and the caregiver staff were attending to the other residents. The auditor then contacted maintenance who promptly contacted the contractor. The contractor then removed his paint and supplies from the outdoor area. Maintenance staff confirmed that the	Ensure external contractors who work in a dementia unit clearly understand the steps that are required to ensure no residents have access to any

<p>in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>			<p>contractor has been orientated to health and safety procedures. During an interview with the contractor, he stated that because the door to the outdoor courtyard was closed, he felt he could leave the area without issue. An incident report was completed.</p>	<p>hazardous substances. 60 days</p>
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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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Numerous examples of good practice were evident, in particular the low rate of bruising at the facility.</p>	<p>The bruising rate relating to manual handling, falls, and managing challenging behaviours around personal cares has reduced significantly over the past year. The clinical manager is responsible for reviewing all bruising incidents. Results are reported to staff daily; at relevant meetings (egg, full facility, caregivers, senior caregivers, night staff, journal club; and on the Ryman social media platform (chatter). All residents on anticoagulants are identified at risk of bruising. Resident care plans are reviewed to ensure adequate interventions are in place for all high-risk and recidivist residents including appropriate equipment (e.g. shin protectors) are in place. A transfer plan has been developed by the physiotherapist for each resident to indicate if a resident is a one or two-person transfer. Education has been undertaken and regularly repeated each month which the clinical manager reports has been significant in raising staff awareness to reducing bruising. Another useful tool, the Ryman social media site (chattr) provides frequent and regular feedback to staff in relation to any trends in data relating to bruising. For the 2021 calendar year, the Ryman group average is 8.2 bruising events/1000 bed nights/month. The bruising rate at Ryman Julia Wallace has been recorded between 2.64 – 5.70 bruising events/1000 bed nights/month.</p>

<p>Criterion 3.5.7</p> <p>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>Infection control statistics are generated monthly and are reviewed by the infection control nurse; reports are provided to the two monthly infection control meetings, clinical meetings, and monthly myRyman meetings. The rate of UTI's have either reduced (rest home level) or consistently remain below the Ryman Group average (hospital and special care unit).</p>	<p>The goal for the project was to maintain consistency of UTI rates within Ryman Group average and below the benchmark of 2 per 1000 bed nights in hospital and special care unit and 4 in rest home. From July 2021 all reported UTIs were reviewed by the CM. Follow up with unit coordinators was undertaken discussing issues of dehydration or reduced fluid intake, reduced physical functioning and self-care ability of rest home residents, poor perineal care, UTI histories and any UTI risk of residents.</p> <p>The CM actively screened the nurse practitioner list and discussed referrals for possible UTIs with unit coordinators and RNs. Review of all residents with recurring UT infections- the reasons for treatment(symptoms), plan in place and outcome/resolution for each infection was reviewed. Discussion of UTI trends at 2monthly IC meetings and at clinical and full facility meetings was undertaken. The RN team undertook education on UTIs, and Bugs are fascinating (Ben Harris video) and present their learnings to RN and Caregiver meetings.</p> <p>In July 2021, 6 monthly indicator results for the consecutive two 6 monthly reports (July to Dec 2020) and (Jan 2021- June 2021) evidenced that total UTI rates were now mostly below the Ryman Group average in Hospital and special care unit and the rates in rest home showed significant continuous reduction</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>	<p>CI</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit, the facility was not using any restraints. Four residents were voluntarily using bedrails as enablers.</p> <p>Restraint policies and procedures are comprehensive and include definitions,</p>	<p>The facility has maintained a restraint-free environment since October 2020. A restraint committee meets twice per year to evaluate the quality initiative of remaining restraint-free. Strategies implemented include regular staff education on maintaining a restraint-free environment, explaining to staff the risks of restraint, what constitutes restraint, interventions, strategies, and accountabilities; residents and families are well-informed at entry to the service regarding the care centre's goal of promoting a restraint-free environment and the benefits this has for their residents; a range of falls prevention strategies are implemented, which help to reduce the need for restraint. Physiotherapy input assists in assessment of residents who are at high risk of falling; the lounge carer role (hospital and dementia) actively engage residents throughout their shift (observed). Residents displaying agitated behaviours are provided with additional companionship, may receive hand massages to help calm them, and are provided with regular fluids and toileting.</p>

		processes and use of restraints and enablers. Staff training has been provided around maintaining a restraint-free environment as well as strategies to manage challenging behaviours and minimise falls	
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End of the report.