

# Evelyn Page Retirement Village Limited - Evelyn Page Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Evelyn Page Retirement Village Limited
<b>Premises audited:</b>	Evelyn Page Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 6 December 2018      End date: 7 December 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	119



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Ryman Evelyn Page provides rest home, hospital (geriatric and medical) and dementia level care for up to 137 residents. On the day of audit there were 119 residents.

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

The village manager is newly appointed and is being supported by head office and the acting regional manager. They have management experience. There is a clinical manager (registered nurse) who oversees the clinical component of the service. There are quality systems and processes being implemented.


## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed that they are provided with adequate information and that communication is open.

Communication records are maintained in each resident record. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. Complaints reviewed are responded to and closed out in a timely manner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a management structure that includes a regional manager who provides support; a village manager who provides operational management and leadership for the site and service and a clinical manager who provides clinical oversight.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by relevant managers. All aspects of the quality programme are discussed at relevant meetings. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

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

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

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

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet 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. Nutritious snacks are provided 24 hours.

## 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.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are policies around restraint minimisation and use of enablers. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were three residents using enablers and sixteen using restraint on audit day, with some using bed rails and/or a chair brief restraint.

## 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. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. The service has successfully managed to contain an outbreak in August 2018.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is complaints register that includes written and verbal complaints and dates and actions taken. Two complaints reviewed indicates that these are being taken seriously with actions taken in timeframes documented in policy and as per the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The complaints process is linked to the quality and risk management system. All complaints are identified as being closed out.</p> <p>There has been one complaint from the Health and Disability Commission and documentation sighted confirms that this has been closed out.</p>
<p>Standard 1.1.9: 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 for that is not covered by the agreement. The</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>information pack is available in large print and in other languages. Staff stated that this can be read to residents who are visually impaired or who need support. 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 (four with relatives in the hospital; one with a relative in the rest home; one with a relative in the special care unit and one from the serviced apartments) stated they were well-informed.</p> <p>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 interpreting services is available if needed for residents who are unable to speak or understand English. Staff stated that family and staff are available to interpret.</p> <p>Residents interviewed, including seven residents using rest home level of care, three using hospital level of care and one from the serviced apartments identified as requiring rest home level of care, confirmed that they can complain if they need to.</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>Evelyn Page is a Ryman retirement village located in Orewa. The service is certified to provide rest home, hospital (geriatric and medical) and dementia level care in their care centre for up to 117 residents. In addition, there are 20 serviced apartments certified to provide rest home level care.</p> <p>There are 40 dual-purpose beds on the ground level where there were 24 residents requiring hospital level care and 16 requiring rest home level care. The hospital wing (40 beds) is on the second floor and was full, with 40 residents. There are two secure care units (Pohutukawa and Summer) with one having 19 beds and one with 18 beds. There is one vacant room currently in the secure care unit. There are three residents requiring rest home level care in the serviced apartments. There are no residents using respite level of care. There is one resident who is under 65 years of age (On a 'of like and interest' contract) in the secure care unit.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Organisational objectives are documented with evidence of monthly reviews and quarterly reporting on progress towards meeting these objectives.</p> <p>The village manager has been in her role for six months, and has been employed by Ryman since August 2018. She has previous managerial experience and has recently completed a masters degree in leadership, and has attended over eight hours of professional development activities related to managing an aged care facility within the past 12 months. She is supported by a regional manager, an assistant manager and a clinical manager/RN.</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>Evelyn Page 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 (the village manager, clinical manager and regional manager) and staff (eight caregivers (rostered over all three shifts), the chef, activities coordinator, health and safety representative/administrator, one care coordinator from the serviced apartments, five registered nurses) and review of management and staff meeting minutes demonstrated their involvement in quality and risk activities.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>Regular resident and family meetings are conducted. Minutes are documented for each meeting. Annual resident and relative surveys are completed with a quality improvement plan developed if there is an area identified for improvement. There was evidence of improvements made to the service as a result of using information from the surveys.</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. Systems are implemented for the collection, analysis and evaluation of quality data. A range of data (eg, falls, pressure injuries, challenging behaviours, infections) is collected across the service using an electronic data system. Data is collated and analysed with evaluation reports completed six-monthly. Data analysis describes variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings (eg, management meetings, full facility meetings, team Ryman meetings). Templates for all meetings document action required, timeframe and the status of the actions. A review of data confirmed that any issue or improvement is signed off as being resolved.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings. A health and safety officer is appointed who has completed external health and safety training. The health and safety officer interviewed was clear regarding their role. 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.</p> <p>Falls prevention strategies are in place including intentional rounding, physiotherapy input, sensor mats to alert when a resident is active and regular exercise programmes.</p>
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<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 and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 15 incident/accident forms for 2018 identified that all are fully completed and include follow-up by a registered nurse. The adverse event reporting process is linked to the quality and risk management system.</p> <p>The village manager and acting regional manager can identify a range of situations that required reporting to statutory authorities (a notification for an outbreak in August 2018) and notification to relevant external authorities regarding the change in village manager. The village manager confirmed that there were no cases presented to the coroner for review for residents in the care centre.</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. Fifteen staff files reviewed (village manager, clinical manager, one registered nurse, five caregivers, one laundry, one activities coordinator and two diversional therapists, two housekeepers, one chef) included an application form, interview and reference checks, signed employment contracts, job description relevant to the role(s) the staff member is in, completion of a general and job-specific orientation programme and annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of practising certificates for visiting health professionals is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. Training is repeated to ensure all staff can attend. There is an attendance register for each training session and an individual staff member record of training. The majority of caregivers who work in the dementia units have completed their required dementia qualification apart from new staff or those in training (all within 18 months).</p> <p>Registered nurses are supported to maintain their professional competency. There are eight registered nurses trained (including the clinical manager), who have completed interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures or treatments, including medication 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 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. There is a minimum of two RNs and eight caregivers on-site at any time. Activities are provided seven days a week in the hospital and dementia unit.</p> <p>In addition to staff registered nurses (RNs), RN cover includes a full-time unit coordinator for the 40-bed dual-purpose rest home/hospital floor, a hospital unit coordinator (RN) for the 40-bed hospital unit and a special care coordinator (RN) for the dementia units. A minimum of one senior caregiver is on duty in the serviced apartments during the night shift, with additional staffing on the morning and afternoon shifts. Staffing throughout the facility meets contractual requirements and is adjusted based on the number of residents and their acuity. This currently includes seven caregivers on the morning and afternoon shifts in the rest home; eight caregivers on the morning and afternoon shift in the hospital and four on the morning and afternoon shifts in the special care unit. There are two registered nurses in the special care unit in the morning and one in the afternoon.</p> <p>Staff were visible during the audit and were attending to call bells in a timely manner, as confirmed by all residents and families interviewed. Staff interviewed stated that overall the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported 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 guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised medication blister packs for regular and 'as needed' (PRN) medications. Medications are managed appropriately in line with required guidelines and legislation. Medication fridge temperature monitoring is undertaken. Medication reconciliation is completed on delivery. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role regarding medicine administration. Standing orders are not used. Residents self-medicating had been assessed by the GP and RN as competent to self-administer.</p> <p>All 15 medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and</p>	<p>FA</p>	<p>The meals at Evelyn Page are all prepared on site. 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, moulied foods) or of any residents with weight loss. The 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</p>

<p>nutritional needs are met where this service is a component of service delivery.</p>		<p>nutritious snacks 24 hours a day.</p> <p>Food safety management procedures are adhered to including storage of food, and temperature monitoring. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses.</p> <p>The residents interviewed were very satisfied with recent changes in the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>InterRAI assessments tools are used for any change in health condition and to develop the long-term/short-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation.</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. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed.</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>Wound assessments, treatment and evaluations were in place for all current wounds reviewed. The register included the number of residents with wounds. Wounds reviewed were: hospital unit - two ulcers, one skin lesion/ rest home three abrasions, two skin tears/ dementia one abrasion, three skin tears. There was no record of any residents with pressure injuries. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include a 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 care staff interviewed.</p> <p>Care plans included involvement of allied health professionals in the care of the resident. This was integrated into</p>

		the electronic myRyman individualised record. Evidence was sighted for speech language therapist, physiotherapist, dietitian, hospice, podiatrist, mental health services and wound care specialist (district nursing services).
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are five activity coordinators who provide a separate Monday to Friday activity programme for the rest home, hospital, dementia care units and serviced apartments. A company diversional therapist (DT) oversees the activity programmes. The activity coordinators attend Ryman workshops and on-site in-services. All hold current first aid certificates. One of the activity team has completed DT qualifications.</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 dementia care units at various times throughout the day 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>An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment and outings. Resident meetings are held two monthly and family meetings six monthly. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents interviewed spoke positively about the activity programme provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Four long-term care files sampled of permanent residents contained written evaluations completed six monthly. The other three files were not yet due for evaluation. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility has three service levels across three floors. The serviced apartments are accessed from the ground floor. There are 40 hospital beds on the ground floor, 40 dual-purpose beds on level 1 and 37 dementia beds split into 2 wings of 19 and 18 beds on level 2. 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 that expires 10 August 2019.</p> <p>The facility employs two maintenance staff (full-time and on call) and 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.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. Currently air-conditioning units are being installed in the serviced apartment area.</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 is provided.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The dementia care unit includes an open plan dining/lounge area. There is free and safe access to an outdoor deck area with 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 been specified in the infection control programme.</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 registered nurse. 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 bi-monthly combined health and safety and infection prevention and control (IPC) meetings.</p> <p>Six-monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Ryman Evelyn Page include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation.</p> <p>There has been one outbreak in 2018 with documentation reviewed indicating that this was managed as per policy. External authorities were notified, and advice and support received.</p>



<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There were three residents using enablers and sixteen using restraint on audit day, with some using bed rails and/or a chair brief restraint.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.