

# Ryman Healthcare Limited - Margaret Stoddart Retirement Village

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## 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:** Ryman Healthcare Limited

**Premises audited:** Margaret Stoddart Retirement Village

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 19 October 2020 End date: 20 October 2020

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit: 48**

# 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

Margaret Stoddart is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home care level care for up to 46 residents in the care centre and rest home level of care for up to 20 residents in serviced apartments. On the day of audit there were 48 residents including 9 residents receiving rest home level of care in serviced apartments.

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

The service is managed by a non-clinical village manager who has been in the role three years. She is supported by a clinical manager who has been in the role one and a half years and has previous experience in palliative care nursing. The residents and relatives interviewed spoke positively about the care and support provided.

The service has been awarded continuous improvements around communication and the dining experience.

## 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.

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

The service complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated, and appropriate to the needs of the residents. The village 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 are in place, which includes in-service education and competency assessments. The resident and families reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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There is an 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 within the required timeframes. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans reviewed have been updated for changes in health status. The general practitioner completes a resident review at least three-monthly.

The diversional therapists provide an activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the group of residents. There is socialisation and some combined activities between care centre residents, serviced apartment and town house residents.

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

The menu is designed by a dietitian at an organisational level and meets the resident preferences. 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 a mix of toilet and hand basin ensuites and full ensuites. There are adequate numbers of communal shower rooms. There was sufficient space to allow the 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.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service has no residents using enablers or restraint. The restraint coordinator maintains a register

## 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 include policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. Covid-19 screening was well managed, and documentation is held on record. Contact tracing remains in place. Adequate supplies of personal protective equipment were sighted throughout the facility.

## 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	43	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code).</p> <p>Discussions with the village manager, clinical manager/RN, regional operations manager, and clinical staff (eight caregivers, two registered nurses (RNs), the diversional therapist and one diversional therapist in training) confirmed their familiarity with the Code. Non-clinical staff including one laundry staff, one lead chef, one housekeeper and a maintenance person were also familiar with the Code. The Code is discussed at resident and staff meetings.</p>
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. Seven rest home resident files reviewed (including one resident in studio apartment and one respite care resident) included written consents. General consents included the consent for photographs and sharing of medical information. Specific consent was obtained such as influenza vaccines. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care.</p> <p>A resuscitation status was signed by the competent residents and witnessed by the general practitioner (GP). Where the resident was unable to make a decision, the GP makes a medically indicated not for resuscitation in consultation with the enduring power of attorney (EPOA). Copies of EPOA and activation status where</p>

and give informed consent.		<p>appropriate was available on the resident file. Copies of advance directives were available where theses had been completed.</p> <p>Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Admission agreements for six long-term resident files under the ARCC had been signed within a timely manner. There was a short-term admission agreement in place for the respite care resident.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. The resident files included information on residents' family/whānau and chosen social networks. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. Residents interviewed confirmed they are aware of their right to access independent advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The activities programmes include opportunities to attend events outside of the facility including activities of daily living, such as shopping. There is an on-site shop and hairdresser available. A community Deans Avenue Precinct society has been developed which the residents are involved with, they attend, and host morning teas for members of the group, attend annual general meetings and community barbeques. The facility has links with several groups in the community which residents attend including Oddessy House, Dementia Canterbury, Oak development trust, Parkinsons society and the Al Noor Mosque. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>The village manager investigates complaints in consultation with the clinical manager. Escalation of complaints to the regional manager is dependent on the severity of the complaint. A complaint register (in hard copy and on the electronic system) is maintained for all written and verbal complaints with dates acknowledged, actions taken, investigation and letters of outcomes or face-to-face meetings with the complainants. Complaints are</p>

		<p>being managed in a timely manner and within timeframes determined by the Health and Disability Commissioner (HDC).</p> <p>Since the previous audit, there have been a total of six complaints lodged in 2018, two in 2019 and none in 2020 (to date). There is evidence of complaints received being discussed in management meetings and staff meetings. All complaints received were investigated to the satisfaction of the complainant.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>An admission information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. The village manager or the clinical manager discusses the information pack with residents/relatives on admission. Large print posters of the Code and advocacy information are displayed on noticeboards throughout the facility. An education session around rights, responsibilities and advocacy services was held during a full facility meeting in November 2019.</p> <p>Interviews with four residents and four relatives confirmed that the services being provided are in line with the Code, and that information around the Code had been provided to them. Residents and relatives interviewed confirmed there was the opportunity to discuss aspects of the Code during the admission process.</p> <p>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>	FA	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code.</p> <p>During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. A tour of the premises confirmed there were areas that support personal privacy for residents. Staff could fluently describe definitions around abuse and neglect that aligned with policy. The interviewed caregivers showed a good understanding of the different types of abuse and neglect and signs and symptoms residents may present. Staff have undertaken annual training on abuse and neglect during June 2019 with good attendance.</p> <p>Residents and relatives' members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The staff of Margaret Stoddard have a relationship with the Kaumatua Maori Mental</p>

as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		<p>Health, Tuahiwi Marae Ngai Tahu, and the nursing tutor at Ara.</p> <p>Team meetings document cultural considerations including Māori language week in TeamRyman meetings, Māori language week also features on the Engage programme. There were no residents at the facility on the day of audit that identified as Maori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Margaret Stoddard has established cultural policies aimed at helping to meet the cultural needs of its residents.</p> <p>The residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. Caregivers describe developing a rapport with residents and ask residents around individual preferences to provide optimum cares. All residents at the facility were able to speak and understand English. A self-directed learning package for cultural awareness was completed by staff in May 2020.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three- yearly. The content of policies 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>Registered nursing staff are available over seven days a week. The service receives support from the district health board which includes visits from specialists (eg, wound care, mental health) and staff education and training. The clinical manager has previous experience in palliative care, infection control, and is the wound champion for the facility. Staff have the opportunity to be involved with health and safety. The service has worked to improve services for residents and has implemented a number of quality initiatives as a result of</p>

		satisfaction surveys, and monthly analysis of quality data. Benchmarking statistics evidence Margaret Stoddard overall remains below benchmark for falls, and infection rates.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	CI	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. Residents and relatives were particularly complimentary when discussing communication during the Covid19 lockdown.</p> <p>The service has exceeded the standard around communication.</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>Margaret Stoddard is a Ryman healthcare retirement village. They are certified to provide rest home level care. There are 41 beds in the care centre, with a further five serviced apartment rooms (certified as rest home level care) currently being utilised as rest home rooms with full ensuite facilities. There are 20 serviced apartments (LTO's) certified to provide rest home level care.</p> <p>On the day of the audit there were a total of 48 residents (39 residents in the care centre including one private paying resident and one resident on respite care) and nine residents in the serviced apartments receiving rest home level care.</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values and beliefs are documented that are specific to Ryman Margaret Stoddard. The village objectives are reviewed quarterly, and progress reported to head office. There are weekly management meetings. The village manager reports to the regional manager who was present on day one of the audit.</p> <p>The village manager (non-clinical) has been in the role for three years and has a background in social work and has four years age care experience at another Ryman facility. The clinical manager has been in her role for 18 months and has previous experience in age care and palliative care.</p> <p>The village manager has attended in excess of eight hours education including Ryman village manager training days, and Oddesey 65 workshops. The clinical manager has attended the senior leadership LEAP programme through Ryman and infection control workshops.</p>
Standard 1.2.2: Service	FA	During the temporary absence of the village manager, the clinical manager would provide this role with support

<p>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>		<p>from the Ryman Christchurch 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>	FA	<p>Margaret Stoddard has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance are reported at the weekly management meetings and also to the organisation's management team. Quality data, quality initiatives and corrective action plans are discussed at the monthly full facility meetings, clinical meetings and other facility meetings held across the site. Meeting minutes are made available to staff. Discussions with the managers and staff and review of management and staff meeting minutes, demonstrated their involvement in quality and risk management activities. 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 is an internal auditing programme set out by head office. The village manager completes non-clinical audits and the clinical manager completes clinical audits. The service develops a corrective action plan for any audit result below 90%. A quality improvement register is maintained. Corrective actions are signed off when completed and audit results are communicated at the management and facility meetings.</p> <p>The facility has implemented processes to collect, analyse and evaluate data including resident and staff accident/incidents, hazards, infections, complaints and audit outcomes, which is utilised for service improvements. Quality improvement plans have been developed for areas identified for improvement including call bell response times, increase in challenging behaviours and falls with injury. Action plans have been implemented and demonstrated ongoing improvements in these areas.</p> <p>Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed</p> <p>Resident and relative surveys are completed annually. Care centre resident survey results for 2020 had improved in all areas from 2019 survey results. The average score was 4.56 out of 5 which was up from 4.38 out of 5 in 2019. Survey results are communicated to residents, relatives and staff through meetings. The relatives' satisfaction survey had not been collated at the time of the audit. The 2019 survey evidenced overall satisfaction with the service.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of</p>

		<p>assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in staff meeting minutes and staff interviews.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee who are representative of the facility. The health and safety representative is also the fire warden for the facility. There is a strong focus on identifying and reporting hazards. The risk register was last reviewed in September 2020. Ryman have initiated "step back" cards that are completed following every incident to analysis and identify the root cause. The noticeboard keeps staff informed on health and safety meetings. Head office sends out health and safety bulletins regularly and alerts for staff information and awareness. There are regular manual handling sessions taken by the physiotherapist.</p> <p>During the Covid19 period, the management reviewed options for an improved means of communication with staff so implemented the social media "Chattr" channel. Leaders were encouraged to touch base with their staff, asking how they were, how were things at home, checking to see if there was any extra support required, any members of the family unwell, and recognising that some partners had either lost hours of work, or had no work. Special Covid19 leave was instigated by the company so staff did not have to use their own leave. Staff were paid extra per hour during the level 4 lockdown. Vulnerable staff continued to be paid throughout the whole pandemic period. All staff were presented with a hamper of essential grocery items, this was to relieve the stress for staff working, and reduce the need to go to the supermarket. Counselling was offered to staff which was free to those who wished to access this service. Staff working during the lockdown were provided with meals, provided with wellness packs containing masks, hand sanitizer, hand cream, vitamin C and paracetamol. Mighty Ape \$50 vouchers were gifted to all staff working to say "thank-you". A concierge service was made available to the unit coordinators and managers. Staff continue to be encouraged not to come to work if they are unwell. Additional sick leave has been provided, so staff feels secure not coming to work if they are unwell, and have no sick leave left. Special Covid19 sick leave codes were entered onto the roster system.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contract a physiotherapist 20 hours a week who is supported by an employed physiotherapy assistant to carry out exercises and walks as directed by the physiotherapist. Care staff interviewed could describe falls prevention strategies as documented in myRyman care plans.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident, with immediate action noted and any follow-up action required. Neurological observations were completed for all unwitnessed falls and where there was the potential for a head injury. The incident reports reviewed document opportunities to minimise future risks.</p>

by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		<p>A review of fifteen electronic incident/accident forms for the facility identified that all were fully completed and include timely follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings, providing an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify significant events that would be reported to statutory authorities, this has included notification of the outbreaks in 2019, and in July 2020, two unstageable pressure injuries and two residents absconding from the building. Reports are sent to head office, who also advise on notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files reviewed; (one clinical manager, one registered nurse, three caregivers, one activities and lifestyle coordinator, one chef, and one serviced apartment coordinator.) included a signed contract, job description, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals. A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice.</p> <p>A register of registered nurse's practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>There is an implemented annual education plan. Each month the service is informed, via TeamRyman regarding what education is to be provided as well as any resources needed. 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. Four registered nurses including the clinical manager have completed their interRAI training. Staff have completed the core competencies relevant to their role.</p> <p>Caregivers are encouraged to gain qualifications with the New Zealand Qualification Authority (NZQA). Currently there are three caregivers and the activities and lifestyle coordinator with Health and Wellbeing level 4, 15 with level 3 equivalent, and four with level 2.</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</p>	FA	<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 service staffing includes.</p> <p>A village manager who works Monday to Friday, and the clinical manager who works Sunday to Thursday. The clinical manager, and village manager are in addition to the rostered staffing. A registered nurse works Friday and Saturday 7.30am to 4pm. There is one registered nurse from 8am to 1.30pm across seven days a week.</p>



service providers.		<p>Care Centre.</p> <p>The morning shift has four caregivers; 1x 7am to 3.30pm, 1x 7am to 3pm, 1x 7am to 12.30pm, and 1x 7.30am to 1pm.</p> <p>The afternoon shift has three caregivers; 1x senior caregiver 3pm to 11pm (medicine competent), 1x 3.30 to 11pm, and 1x 4pm to 9.30pm.</p> <p>Serviced Apartments</p> <p>The unit coordinator (senior caregiver) works Monday to Friday from 7am to 3.30pm. A senior caregiver works the weekends from 7am to 3.30pm. they are supported by one caregiver from 8am to 12midday, and the activities and lifestyle coordinator from 10am to 4pm.</p> <p>The afternoon shift has two caregivers; 1x senior caregiver (medicine competent) from 3pm to 11pm and 1x 5pm to 7.30pm.</p> <p>Night shift is covered by two caregivers (one medication competent)</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident's individual record within 24 hours of entry. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files were protected from unauthorised access. Entries were dated and included relevant caregiver or registered nurse, including designation. The electronic system (myRyman) demonstrated service integration of resident records.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service provides an information pack available for potential residents/families/whanau. There is a welcome for residents on admission that includes a book published by residents of Margaret Stoddart.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term care.</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>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file including Covid-19 screening tools. All relevant information is documented and communicated to the receiving health provider or service including advance directives or medical care guidance documentation. Transfer notes and discharge information was available in the hard copy 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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All medications for the rest home and rest home serviced apartment residents are stored safely in the rest home medication room. Registered nurses and senior caregiver's complete annual medication competencies and attend medication education. Medication reconciliation of monthly blister packs and as required blister packs is checked by an RN and documented on a reconciliation checklist. Any errors are fed back to the pharmacy. There were four rest home residents who were self-medicating with a self-medicating assessment in place which had been reviewed three-monthly by the GP. The medication fridge temperatures are taken weekly and within the acceptable range. Medication room air temperatures are taken and recorded daily. All eye drops in medication trolley had been dated on opening. There are no standing orders, however there were two medications (one a restricted medication) that were being held as practitioner standing order (PSO) initiated during Covid-19 lockdown (refer GP interview 1.3.3). There is a draft policy in place for PSO. The pharmacist (interviewed) checks the stock weekly.</p> <p>The service uses an electronic medication system. Fourteen medication charts were reviewed (13 electronic and one paper-based). All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that regular medications were administered as prescribed. As required medications had the indication for use documented. The effectiveness of as required medications has been recorded in the electronic medication system and in the progress notes.</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</p>	CI	<p>All food and baking are prepared and cooked on-site. The kitchen is adjacent to the large rest home dining room which also accommodates serviced apartment residents and has a conservatory dining room for townhouse residents.</p> <p>The head chef works Monday to Friday 8am to 5pm and is supported by a weekend chef, morning and afternoon kitchenhands. All food services staff have completed food safety training. The project delicious seasonal menu for Margaret Stoddart has been adjusted to provide one main option and vegetarian option. There are alternative foods offered for known dislikes. The organisational dietitian has reviewed the menu. Special diets include pureed meals and one gluten free meal. Pure foods are used for pureed meals and as a base for other</p>

delivery.		<p>soups and foods. The service has focused on improving the dining experience offering preferred meals and refurbishing the dining room.</p> <p>The service has a current food control plan. End cooked temperatures, fridges, freezer, cooking and cooling and incoming goods have temperatures checked and recorded. All foods were stored correctly, and date labelled. A cleaning schedule is maintained. The chemical provider completes dishwasher temperature and chemical efficiency checks monthly. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings and direct contact with the food services staff. Resident and relatives interviewed spoke positively about the meals provided. The survey results demonstrate an increase in food satisfaction.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>In all the files reviewed, an initial assessment (part 1 and 2) and relevant risk assessment tools had been completed on admission. The outcomes of interRAI assessments for long-term residents and risk assessments were reflected in the electronic care plans reviewed. Additional assessments such as (but not limited to) behavioural, falls, nutritional, pressure injury, pain, wound and physiotherapy assessments were completed according to need. There are a number of assessments completed that assess resident needs holistically such as cultural and spiritual and activities assessments. The assessments generate interventions and supports completed by the RNs that are transferred to the myRyman care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p>

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The electronic care plans for all resident files (including the respite care) outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met. The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall, likes and dislikes. Residents/relatives sign a care plan acknowledgement form that evidences resident/family/whānau involvement in the care planning process. Relatives interviewed confirmed they were involved in the development and review of care plans. Care plans included involvement of allied health professionals in the care of the resident such as the GP, physio, geriatrician, dietitian, wound nurse, older persons health service and community gerontology nurse.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>The residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met and their expectations of the service were being met. When a resident's condition changes, the registered nurse initiates a review and if required a GP or nurse specialist consultation. The care plans are updated with any changes to care and required health monitoring interventions for individual residents are scheduled on the RN or caregiver work log.</p> <p>Wound assessments, treatment and evaluations were in place for six wounds. There were no pressure injuries on the day of audit. The RN wound care champion/clinical manager has attended wound care training. Wound assessments include the size of the wound, photographs and consider presence of pain. Non-healing and chronic wounds have been referred to Nurse Maude for input into wound healing/dressings and management. All wounds are linked to the long-term care plan. The service has pressure relieving resources available if required.</p> <p>Continence products are available and resident files included 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 RNs interviewed.</p> <p>Monitoring requirements are scheduled on the work log and used to monitor a resident's progress against clinical/care interventions for identified concerns or problems. Monitoring forms reviewed on the electronic work logs included blood pressure, weights, blood sugar levels, pain, behaviour, bowel records, food and fluids, intentional rounding and neurological observations. Intentional rounding is determined by the residents need including toileting or falls risk.</p>
Standard 1.3.7: Planned Activities Where specified as part	FA	The service employs two diversional therapists (DT) to implement the Engage programme across the rest home and serviced apartments. The rest home DT works from 9am – 4.30pm Monday to Friday and the serviced apartment DT works from 10.30 – 4pm. There are resources available in the weekends for residents, families

<p>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>and care staff to access. The rest home residents in serviced apartments can choose to attend activities in the rest home or serviced apartments.</p> <p>The Engage programme has been implemented. There are set activities with the flexibility to add activities that are meaningful and relevant for the resident group including (but not limited to); Triple A exercises, mind benders, board games, news and views, memory lane, crafts, gardening, walks, happy hour, hand massage and aromatherapy, sing-a-longs and indoor bowls. There are a number of clubs such as men's club, book club, painting club, knit and knatter and card club. Townhouse residents volunteer assistance with exercises, serving drinks at happy hours, library duties and leading the village choir. The choir and men's club include residents from the care centre, serviced apartments and townhouses. Church services are combined for all residents. There is weekly entertainment and twice weekly outings/scenic drives.</p> <p>Themed events and festive occasions are celebrated. Residents are invited to attend community events. The residents are currently involved in choosing another cat for the home.</p> <p>Activities continued during the Covid-19 lockdown period whilst maintaining social distancing. Hallway activities such as exercises, housie and sing-a-longs occurred. One on one crafts and other activities were provided in resident rooms. There were zoom meetings with families on the resident room devices.</p> <p>Resident life experiences and an activity assessment is completed for residents on admission. The resident/family/whānau (as appropriate) are involved in the development of the activity plan which is incorporated into the myRyman care plan. The activity plan is evaluated six-monthly with the MDT review. Residents/relatives can feedback on the programme through the two monthly resident meetings and annual surveys. The residents and relatives interviewed stated they were very happy with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Six long-term files identified that the initial assessment had been evaluated within 21 days, in consultation with the resident/relative prior to the development of the long-term care plan. Long-term care plans had been evaluated six-monthly for long-term residents who had been at the service six months. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. Written evaluations describe the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. The multidisciplinary (MDT) review includes input from the RN, caregivers, DT, GP, resident, relative and any other health professionals involved in the resident's care. A record the MDT review is kept in the resident hard copy file. The family are invited to attend the MDT review and are notified of any changes if unable to attend. Care plans had been updated with any changes to health and care. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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. 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, Nurse Maude and contracted allied professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>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. The chemical provider monitors the effectiveness of chemicals. Relevant staff have completed chemical safety</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>	FA	<p>The building has a current building warrant of fitness. The facility employs a part-time maintenance person who works between two sites. The maintenance person ensures daily maintenance requests recorded in the register are addressed. The full-time gardener also assists with maintenance requests. There are preferred contractors available for essential services. A planned maintenance schedule has been maintained and includes electrical testing and tagging, calibration and functional checks of medical equipment, call bells checks and resident hot water temperature monitoring. Temperature recordings reviewed were below 45 degrees Celsius.</p> <p>Environmental improvements include double glazing of all rest home room windows, installation of heat pumps/air conditioners in all lounges, new furnishings and new outdoor umbrellas. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Courtyard paving has been improved allowing safer access for residents to the outdoor areas. Seating and shade are provided.</p>

		The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. Most rest home beds have been replaced with electric high-low beds as part of the bed replacement plan.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All rest home bedrooms are single occupancy and have toilet and basin ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. There are adequate communal showers available with privacy locks and privacy curtains in place. There are some rest home rooms in the serviced apartment wing which have full ensuites. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All residents' rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. The layout of rooms had been changed to accommodate the new electric beds.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	The facility has a large communal combined dining room for rest home and serviced apartment residents. The large main lounges (rest home and serviced apartments) have seating placed to allow for individual or group activities. A smaller lounge opens out onto the internal courtyard. The lounge is available for quieter activities such as reading and for visitors.

accessible areas to meet their relaxation, activity, and dining needs.		
<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. All linen and personal clothing is laundered on-site. There are designated laundry and housekeeping staff. The laundry operates from 10am to 4pm seven days a week. There is a one door entry to the laundry with defined clean/dirty areas. There is a sluice tub located in the laundry with available personal protective equipment. Laundry equipment is serviced regularly.</p> <p>There are three cleaners on daily for the rest home and serviced apartments who start and finish between 7.30 to 1pm. There is additional cover to allow for spring cleaning of resident rooms. There is a large housekeeping room for the secure storage of cleaning trolleys, equipment and chemicals.</p> <p>All staff have completed chemical safety and infection control education. Laundry and cleaning audits were completed as per the Ryman programme. The chemical providers monitor the laundry and cleaning process.</p> <p>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.</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. Orientation includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The facility has an approved fire evacuation plan and fire drills take place six-monthly. The last fire evacuation drill occurred on 8 October 2020. Smoke alarms, sprinkler system and exit signs are in place.</p> <p>Emergency lighting is in place, which runs for at least two hours. The facility has an on-site diesel generator to run essential services. There is a civil defence kit located in a central location. Supplies of stored drinkable water is stored in large holding tanks. There is sufficient water stored to ensure three litres per day for three days per resident. There are alternative cooking facilities available with barbeques and gas hobs in the kitchen.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advised that they conduct security checks inside at night, in addition to an external contractor who checks the external.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight.



Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<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. There is an infection prevention and control responsibility policy that included a chain of responsibility and an infection prevention and control coordinator's job description. The clinical manager is responsible for infection prevention and control at the facility and has previous experience in infection control coordination.</p> <p>The infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet two-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the TeamRyman calendar. The facility had developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. Notices are displayed on entry to the facility reminding visitors not to visit if they are unwell.</p> <p>Due to current Covid-19 guidelines, all visitors and contractors must complete a wellness declaration and sign into the facility. There were adequate supplies of infection control equipment sighted in the case of outbreaks. A good supply of hand gel, masks and aprons are available.</p> <p>There have been three outbreaks at the facility since the last audit, two in 2019 (influenza and RSV) and a norovirus outbreak in July 2020. All were reported documented and managed well. Debrief meetings were held post outbreaks.</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</p>	FA	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control updates. Ryman is a member of Bug Control. The infection control team is representative of the facility. Resident care plans reviewed included comprehensive documentation for any known infections.</p> <p>External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>The requirements during the Covid-19 lockdown and practices at all different levels have been adhered to. There are folders containing all information and processes for each level of lockdown. During the lockdown</p>

organisation.		period, staff were provided with separate changing facilities. All staff had very clear guidelines on infection control and laundering of uniforms. Residents adhered to the isolation and temperature checking. Activities were set up in hallways so residents could participate while adhering to social distancing. Education sessions were provided for hand washing and infection control was held in April 2020. The correct techniques of donning and doffing personal protective equipment (PPE) was held in April 2020, and the outbreak drill procedure was held in October 2020. The facility continues to maintain current regulations, ensuring all visitors complete the electronic wellness declaration and sign in. Staff interviewed stated they felt well looked after and were well informed of changes during the Covid-19 period.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. Online training was provided around PPE, infection control and handwashing was provided as required in April 2020 with self-directed learning and via a full facility meeting.

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined two-monthly infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer use 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 GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection rates are benchmarked across the organisation.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. The clinical manager is the restraint coordinator and has a job description that defines the role and responsibility of the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. All restraint and enablers are reported to TeamRyman monthly. On the day of the audit, there were no residents using restraint or enablers. The caregivers interviewed were knowledgeable around the differences between restraint and enabler processes and definitions.</p>

# Specific results for criterion where corrective actions are required

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

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

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

No data to display
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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
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	CI	The manager promotes the open-door policy and makes herself visible to residents and relatives. Photo boards are displayed of staff and their role at the residents' request through meetings. There are a variety of ways the staff communicate with relatives. Relatives were positive around the text messaging system used to notify them of resident accidents, changes in condition or general practitioner GP visits. Quarterly newsletters are used to update relatives of what's been happening around the facility and upcoming events. Education was provided to staff around communication and sensory loss, and communication with residents in 2019. A training session was held in 2020 around distressed behaviour. A more structured approach to multi-disciplinary team meetings, which the resident and relatives are invited	<p>The service has a non-English speaking resident and a non-English speaking staff member. The service has implemented quality initiatives to assist with communication.</p> <p>The non-English speaking resident also has a family member for translation. Day to day communication with staff is through flash cards with pictures and translation in the residents' language, and hand gestures. Google translate has been used, and a smart TV has been installed in the resident's room, so they have access to programmes in their own language. The staff have learned some words in this language to help with communication. As relationships have been built, the resident is now attending more activities and events happening in the facility.</p> <p>Complaints are discussed at all meetings. Residents are encouraged to voice concerns and are reminded of the 'open door' policy of management at all resident meetings. All concerns and</p>

		<p>to attend has occurred. This has ensured information is gathered from all sources. This has provided a more holistic approach to care planning and the information contained in the care plan. Residents and relatives are happy with the contribution they have made to the care planning process. The service has implemented a number of quality initiatives to assist with communication.</p>	<p>complaints are dealt with immediately, corrective actions are discussed and implemented as soon as possible.</p> <p>The myRyman system assists caregivers to access preferences and routines quickly to ensure care is individualised and right for the resident. If there are concerns, this can be entered on the system and escalated to the RNs instantly. The 'village friends' initiative has helped 'new' residents navigate their way through the routines of the facility and activities programme. Caregivers interviewed describe taking the time to get to know their residents likes, dislikes, preferences and general routines to provide the best care. As a combined result of the increased awareness in communication and escalation of resident and relative concerns, the satisfaction rate in these areas have continued to increase. Resident satisfaction rates around communication have gone from 4.11 in 2018, to 4.22 in 2019 to 4.56 in 2020. Relatives from 4.50 in 2019 to 4.69 in 2020.</p> <p>Complaints management in the resident survey has remained the same in 2019 and 2020 at 4.44. Relatives satisfaction has increased from 4.57 in 2019 to 4.69 in 2020. There have been no complaints received in 2020 to date.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the</p>	CI	<p>The service implemented a project in January 2019 to improve the dining experience for residents. A quality improvement plan was developed in consultation with management, food services, staff and residents. The resident survey results evidence there has been an increase in satisfaction around the dining experience.</p>	<p>The chef attends resident meetings and following discussion with residents and the hospitality manager it was agreed to modify the Project-delicious menu to include family favourites and food specifically designed to cater for and satisfy smaller village clientele. There is one option for the main meal and a vegetarian option. Alternative foods are provided for residents with dislikes. The chef is visible at the servery serving meals and continues to have discussions with residents regarding the meal service. There was education provided for all staff on nutrition and hydration, sensory loss, dining etiquette, meal presentation and special diets. The dining room décor was reviewed including the high ceilings which emphasized the noise levels from staff clearing dishes away and resident having to raise voices for conversations. The noise levels were difficult for residents especially those hard of hearing. The dining room was refreshed with panting, new wallpaper and installation of acoustic panels on the ceiling which was successful in</p>

consumer group.			reducing noise levels. Resident meeting minutes evidence residents are enjoying their dining experience and are able to socialise for longer enjoying and finishing their meals. In January 2019, weight loss was 31.4% reducing throughout the implementation of the project to its lowest point in August 2020 at 5.9%. There has been an increase in resident meal satisfaction and dining experience from 4.07 in 2019 to 4.22 in 2020.
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End of the report.