

# Bruce McLaren Retirement Village Limited - Bruce McLaren Retirement Village Limited

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bruce McLaren Retirement Village Limited
<b>Premises audited:</b>	Bruce McLaren Retirement Village Limited
<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: 5 October 2020 End date: 6 October 2020
<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>	123



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

## General overview of the audit

Bruce McLaren is part of the Ryman Group of retirement villages and aged care facilities. They provide hospital ( medical and geriatric), rest home and dementia level care for up to 122 residents in the care facility and rest home level care for up to 20 serviced apartments. On the days of the audit, there were 123 residents, including one resident receiving rest home level of care in serviced apartments.

The service is managed by a village manager who is supported by an assistant village manager and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

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 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.

This surveillance audit identified improvements required around completion of neurological observations; completion of interRAI assessments; and documentation of corrective action plans as part of the quality improvement programme.

## 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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service.

Information about services provided is readily available to residents and families. Residents and family reported that communication with management and staff is open and transparent. They also stated that they understand how to make a complaint. Complaints and concerns have been managed in a timely manner as per policy 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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned and coordinated to meet the needs of the residents. A village manager, assistant to the manager and clinical manager are responsible for the day-to-day operations. Village goals are documented for the service with evidence of regular reviews. Key components of the quality and risk management programme are documented and include management of complaints, an internal audit schedule, completion of satisfaction surveys, analysis of incidents and accidents, and an implemented health and safety programme.

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

Registered nursing cover is provided 24 hours a day, 7 days a week. Rosters and interviews with staff, residents and family indicated that there are sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs.

## 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.		Some standards applicable to this service partially attained and of low risk.
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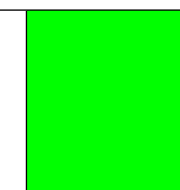
There is an information/welcome pack that includes information on each level of care. Registered nurses are responsible for initial assessments, risk assessments, interRAI assessments, and development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, are individualised, and evaluated six-monthly. The general practitioner reviews residents on admission and at least three-monthly.

The activity team implement the Engage activity programme in the rest home/hospital wings and dementia unit that ensures the abilities and recreational needs of the residents is varied and interesting, and involves entertainers, outings, and community visitors.

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. There are three-monthly GP medication reviews.

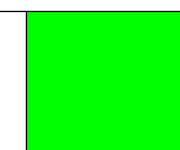
Meals are prepared on site. The 'project delicious' menu is designed by a dietitian at organisational level and provides meal options including gluten free and vegetarian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a building warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. The bedrooms, hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. The environment is warm and comfortable.

## 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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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents assessed as requiring either the use of restraint or the use of an enabler. Staff receive ongoing education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. There has been one outbreak. All Ryman Covid-19 precautions have been fully implemented.

## 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	13	0	3	0	0	0
<b>Criteria</b>	0	38	0	3	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>	<p>FA</p>	<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 and on each level in the foyers of the care centre. Residents in the serviced apartments are able to get complaints forms from reception or from any of the levels in the care centre.</p> <p>Interviews with residents and family members confirmed their understanding of the complaints process. Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register is in place. Six complaints have been lodged for 2020 (four from residents including two from residents or family in the rest home and two in the hospital). Three complaints were reviewed during the audit. Each was investigated and resolved within timeframes determined by the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is evidence of the complaints being discussed in relevant meetings with appropriate follow-up actions taken.</p> <p>The following managers and staff were interviewed: one village manager, one assistant to the manager and the clinical manager; six healthcare assistants (HCAs) including two working in the rest home, two in the hospital and two in the dementia unit; one registered nurse; the unit coordinators from hospital and dementia units, maintenance staff; executive chef; two housekeepers; two diversional therapists and one activities coordinator. All were familiar with the complaints policy and relevant processes.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Seventeen adverse events reviewed included documentation that family had been notified of an incident. Family members interviewed (including one from the rest home, two dementia and two hospital) confirmed they are notified following a change of health status of their family member. Residents interviewed (five from the rest home and five from the hospital) confirmed that there was good communication from the management team and registered nurses (RNs).</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p> <p>There has been extensive communication to residents and relatives around Covid-19. This included provision of information around infection control practices put in place.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Bruce McLaren Retirement Village is located in Auckland. The facility is modern and spacious and extends across a sloping section. There are 122 beds in the care centre along with an additional 20 serviced apartments certified for residents assessed at rest home level of care. The facility has four levels. Level one (ground floor) and level two have serviced apartments and dual-purpose beds. Level three has serviced apartments with a secure entrance to the dementia unit (special care unit). The dementia unit has 41 beds across two separate secure units (with a shared nursing station).</p> <p>On the day of audit, there were a total of 123 residents. There were 25 residents requiring rest home level of care; 41 residents in the dementia unit (full occupancy with 20 residents in one unit and 21 in the other); 54 residents requiring hospital level of care. There were also three residents occupying serviced apartments identified as requiring rest home level of care. One resident in the dementia unit was under a respite contract; one resident in the dementia unit was identified as a young person with a disability (YPD) and under a YPD contract; and one resident in the hospital was under an Accident Corporation contract (ACC). All remaining residents were on the age-related residential care (ARRC) contract.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually, specific to Bruce McLaren. Each objective includes an action plan and person(s) responsible. There are specific projects with action plans related to clinical, health and safety, human resources, and resident/relative feedback. Details of progress are reported quarterly.</p> <p>The village manager at Bruce McLaren has been in Ryman facilities for 12 years as administrator, assistant manager and for the past three years, as village manager. They have completed the Ryman leadership programme. The village manager is supported by an assistant manager (previously in reception roles for four years) and a clinical manager who has been in the role for two years and who has a background as a clinical</p>

		<p>manager in home care services for eight years. They are supported by the regional manager who was on site during the audit. The managers are supported by a unit coordinator (UC) in each area. All unit coordinators are registered nurses.</p> <p>The managers have maintained more than eight hours annually of professional development related to managing an aged care service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management system that is directed by head office (Ryman Christchurch) is established and implemented. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with managers and staff, and the review of meeting minutes demonstrated the collective involvement of managers and staff in quality and risk management activities.</p> <p>Resident meetings are held quarterly for each service level and relative meetings are scheduled six-monthly. The village manager attends the meetings, and minutes are maintained. Resident and relative surveys are scheduled to be completed annually.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service-appropriate management systems, policies, and procedures are developed, implemented, and regularly reviewed, meeting sector standards and contractual requirements.</p> <p>The facility has documented processes to collect, analyse and evaluate data. There are quality improvement plans documented when issues are identified from relative and resident surveys and from internal audit reports. Where issues are identified in meeting minutes and through analysis of data, there is a lack of documented action plans and subsequent meetings or reports do not reflect follow-up or resolution.</p> <p>Results of surveys are communicated to staff across a variety of meetings including full facility meetings, clinical meetings, restraint, caregiver, health and safety, activities, and infection control meetings. The internal audit programme is followed as per the schedule.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. A health and safety officer was interviewed, and they were able to describe their role as per the job description. 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.</p>

		<p>Health and safety data is tabled at staff and management meetings. A review of the risk register, and the maintenance register indicated that there is resolution of issues identified. All new staff and contractors are inducted to health and safety processes. There is also annual in-service training and competency assessments.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls with a range of examples provided (eg, providing falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; routine checks of all residents specific to each resident's needs (intentional rounding); the use of sensor mats and night lights; and increased staff awareness of residents who are at risk of falling. Care staff interviewed were knowledgeable in regard to preventing falls and identifying those residents who were at risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise, and debriefing. Individual incident reports are completed electronically using VCare for each incident/accident with immediate action(s) and any follow-up action required evidenced.</p> <p>A review of 17 incident/accident reports (including witnessed and unwitnessed falls, pressure injury, challenging behaviours) included follow-up by a registered nurse. Consistent evidence of timely neurological observations were not always documented if there was a suspected injury to the head or an unwitnessed fall (link 1.3.6.1).</p> <p>The managers and unit coordinators are involved in the adverse event process via regular management meetings and informal meetings during the week that provide an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations would be reported to statutory authorities, (eg, Section 31 reports were sighted for pressure injuries).</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</p>	FA	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation, and staff training and development. Thirteen staff files were randomly selected for review (clinical manager, assistant manager, hospital unit coordinator, unit coordinator dementia, village manager, two registered nurses, three HCAs, one kitchen manager, one activities coordinator, one administrator). Each file included an application form and two reference checks, a signed employment contract, job description, police check, and completed orientation programme. All files reviewed also included a current annual performance appraisal.</p> <p>Practicing certificates for health practitioners including the registered nurses, (doctors and nurse practitioner, physiotherapists, dietitian, pharmacists) are retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice.</p>

<p>legislation.</p>		<p>The general orientation programme that is attended by all staff includes Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. HCAs are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. Staff also complete annual competency questionnaires. RNs are supported to maintain their professional competency. Of the 17 registered nurses (including unit coordinators), 17 have completed interRAI training. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>The following numbers of staff have completed certificates: two have certificates in health and wellbeing level two with three who have completed foundation level two; five who have completed level three; 20 who have completed level four; 30 who have completed level three dementia unit standards; eight in the process of completing dementia unit standards; two who have a diploma in health service level seven; and two diversional therapists level four. All HCAs who work in the dementia unit have completed dementia training.</p> <p>There are implemented competencies for RNs and HCAs related to specialised procedures or treatments including (but not limited to) medication competencies and insulin competencies.</p> <p>The service has not used bureau staff since mid-March 2020. Staff turnover from April 2018 was at 16.8% turnover and it has dropped to 8.2% on 30 June 2020.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, resident services manager, and clinical manager work Monday – Friday.</p> <p>Four unit coordinators (one hospital/RN, one rest home/RN, one dementia/RN, one serviced apartments/EN) work full time. They stagger their schedules for seven day a week cover across the two units that are currently open.</p> <p>Level one (occupancy 13 hospital and 25 rest home residents) is staffed with a unit coordinator, four HCAs, one RN on the AM shift. There are five HCAs on the PM shift including two who complete a short shift and two HCA overnight.</p> <p>Level two (occupancy 41 hospital residents) is staffed with a unit coordinator on the AM shift along with eight HCAs (four short shift) and two RNs; six HCAs in the afternoon (including three short shift) and two RNs; and three HCAs and one registered nurse overnight.</p> <p>The dementia unit is split into two wings with a shared nursing station (20 residents on one side and 21 on the</p>

		<p>other). In the morning there are four HCAs (including two short shifts) split between the two units, a registered nurse and unit coordinator across both. In the afternoon, there are two long and two short shifts (1500-2100) plus one lounge HCA who works from 1600-2000 along with one registered nurse. Overnight there are three senior HCAs.</p> <p>Service apartments (three rest home level residents) is staffed with one-unit coordinator/EN five days a week and a senior caregiver the remaining two days. There are two HCAs and one servery assistant in the afternoon. Staff from level two respond to any calls in the serviced apartments overnight. The call system is linked to their pagers.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that 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. All medications are stored safely in each of the three units. Registered nurses and senior caregivers' complete annual medication competencies and education. Registered nurses complete syringe driver training. Medication reconciliation of medication is checked by an RN. Any errors are fed back to the pharmacy.</p> <p>Monthly medication audits are completed. There is one rest home and one hospital resident self-medicating with a self-medicating assessment in place. The medication fridge temperatures are taken weekly, and the room air temperatures are taken and recorded daily. Temperatures have been within an acceptable range. There are no vaccines stored at the facility. All eye drops, creams and sprays were dated on opening. There is a bulk supply stock for hospital residents which is checked weekly for stock levels and expiry dates. 'As required' medications and resident stock is checked monthly for expiry dates.</p> <p>The service uses an electronic medication system. Sixteen medication charts were reviewed from across the three levels of care. All medication charts had photographs, and 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 were 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</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on site. The executive chef is supported by a team of chefs and kitchenhands. All food services staff have completed induction, food safety training and chemical safety.</p> <p>There is a four weekly seasonal menu with three menu choices for the midday meal and two choices for the evening meal, including a vegetarian option and gluten free foods. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Resident dislikes are accommodated, such as fried rice.</p>

<p>nutritional needs are met where this service is a component of service delivery.</p>		<p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. Pureed meals are provided. Lip plates are available to encourage residents' independence with meals. All meals are plated in the kitchen and delivered to the units in scan boxes. Special diets are name labelled. The food services are involved in catering for resident special events and functions and host fine dining monthly. Each unit has a satellite kitchen. All units including the dementia unit have access to snacks for the residents at all times. Residents commented that there is always lots of food available.</p> <p>The service has a food control plan that has been registered and the service is waiting for verification (due to Covid-19). Temperatures are taken and recorded for fridges, freezer, end-cooked foods, and incoming goods. All foods were stored correctly, and date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP or NP visit or a referral to a nurse specialist. 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 nine wounds at hospital level care. This included six pressure injuries (five grade two and one unstageable) and ten wounds at rest home level (nine skin tears and one pressure injury grade two). There were six minor wounds in the dementia care unit. There is adequate pressure relieving resources available. All pressure injuries were facility acquired. In total there were five residents with pressure injuries (link to 1.2.3.8). All wounds are linked to the care plans. Photos were taken where relevant. The clinical manager reviews all wounds weekly. Referrals are made as necessary to the dietitian and wound nurse specialist.</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 forms are set up on the electronic work log and include blood pressure, weight, blood sugar levels, pain, behaviour, repositioning charts, food and fluids, intentional rounding, and neurological observations, however not all neurological observations for unwitnessed falls or for a fall with a head injury had been completed as per protocol.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a diversional therapist (DT) and three activities coordinators. Activities are provided over seven days on the hospital and dementia units and over five days for the rest home and serviced apartments. The activities team described how they adapt activities daily depending on the residents. The team described how feedback is obtained and what alternatives have been made available to residents as a result of feedback (such as high teas, gardening and celebrating golden wedding anniversaries). There is a dementia specific activity programme in place and all residents in the dementia unit have a 24-hour activity plan documented.</p> <p>The Engage programme has been implemented. There are set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including (but not limited to); Triple A exercises, board games, news and views, crafts, gardening, walks, men's group, sensory activities including pet therapy, themed events and celebrations. Rest home residents in serviced apartments can attend either the serviced apartment or rest home/hospital programmes.</p> <p>Some activities are integrated for all residents including weekly entertainers and happy hour and church services. Families are invited to attend activities. Community links include pre-school children, choir groups and pet therapy. There are weekly van outings for each of the units (four trips a week in all). The service has two vans and hires a mobility van for hospital residents.</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. The activity plan is incorporated into the myRyman care plan and evaluated six-monthly with the MDT review. Residents/relatives can feedback on the programme through the resident and relative meetings.</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>Three resident files reviewed of residents who had been at the service six months, identified that long-term care plans had been evaluated by registered nurses. Care plans had been updated with any changes to health and care.</p> <p>Written evaluations described the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review.</p> <p>The multidisciplinary (MDT) review includes the RN, caregivers, DT, GP/NP, physiotherapist, resident, relative and any other health professionals involved in the resident's care. A record of the MDT review is kept in the resident file. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP/NP visits.</p>

<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>There is a building warrant of fitness displayed that expires 14 October 2020, the process for the new warrant of fitness was in progress at the time of audit.</p> <p>A reactive maintenance and planned maintenance schedule are maintained. There is a monthly checklist for planned maintenance including the calibration of medical equipment, functional testing of electrical equipment and hot water temperatures in resident areas. Hot water temperatures in resident areas are stable below 45 degrees Celsius. The maintenance person has completed an electrical testing certificate.</p> <p>Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a small upstairs outdoor balcony area in the hospital and a larger secure one in the dementia unit. All outdoor areas have seating and shade.</p> <p>There is safe access to all communal areas. Residents are able to access outdoor areas safely or with supervision. Seating and shade are provided.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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 policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the online resident files. Infections are included on an electronic register and the infection prevention coordinators complete a monthly report. Monthly data is reported to the infection control committee and meeting minutes are available to staff. Staff are informed of surveillance through the variety of clinical meetings held at the facility.</p> <p>The infection prevention and control programme links with the quality programme including internal audits.</p> <p>There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking against other Ryman facilities occurs. Quality improvements are commenced for any areas identified for improvement.</p> <p>Quality improvements are commenced for any areas identified for improvement (eg, additional training for staff around wound care following a spike in wound infections in the dementia unit). One gastroenteritis outbreak was well managed during August 2019. Public Health were informed, and staff followed policies around outbreaks.</p> <p>Ryman Bruce McLaren has implemented the Ryman Covid-19 precautions. All visitors wear masks, have temperatures recorded and must complete health screening. An additional cleaning schedule has been implemented. Weekly updates from the central office have been sent to all Ryman facilities including Bruce McLaren.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>The clinical manager is the restraint coordinator. On interview they confirmed knowledge around both restraints and enablers. During the audit, there were no residents using any restraints or enablers.</p> <p>Staff training including staff competencies are implemented addressing restraint minimisation and enablers, falls prevention and analysis, and the management of challenging behaviours. This begins during their induction to the service and continues annually.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Quality improvement plans are documented when there are issues identified in the relative and resident surveys. There is limited evidence of resolution of issues when these are identified in meeting minutes and a lack of documentation of corrective action plans and evidence of resolution when some other data shows issues following analysis. This includes, for example, follow-up of issues related to challenging behaviour in June 2020 documented in the clinical meeting with similar issues raised in the July meeting. In July 2020, it was noted that pressure injuries were ‘creeping up’ and in the September meeting, pressure injuries were again noted with a slight increase noted in the dementia unit. Action plans and evidence of follow up of these issues was not documented.</p>	<p>Corrective action plans and evidence of resolution of issues is not always documented when issues arise.</p>	<p>Document corrective action plans and evidence of resolution of issues when issues are identified.</p> <p>180 days</p>

<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	<p>PA Low</p>	<p>All residents on the care floors have timely interRAI assessments. The coordinator described how the interRAI information had been applied for, the three rest home level residents in the serviced apartments, but this had not been received as yet. All three had myRyman assessments and a care plan and all three had been at rest home level for a considerable period of time.</p>	<p>Three rest home level residents in the serviced apartments do not have interRAI assessments.</p>	<p>Ensure that all resident under the ARRC agreement have timely interRAI assessments.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Monitoring forms reviewed on the electronic work logs included blood pressure, weight, blood sugar levels, pain, behaviour, repositioning charts, food and fluids, intentional rounding, and neurological observations, however not all neurological observations had been completed as per protocol.</p>	<p>Six of seven residents' electronic progress notes for those residents who experienced an unwitnessed fall failed to indicate the timeliness for initiating and continuing to complete neurological observations as per the falls protocol. The clinical manager reported that this was an issue with the electronic system and that he believed neurological observations were being done by the nursing staff in a timely manner.</p>	<p>Ensure the electronic system used to record neurological observations reflects the actual time(s) of neurological observations as per protocol for unwitnessed falls.</p> <p>90 days</p>



## 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.

No data to display
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End of the report.