

# Ryman Healthcare Limited - Ngaio Marsh Retirement Village

---

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Ryman Healthcare Limited

**Premises audited:** Ngaio Marsh Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 15 October 2020 End date: 16 October 2020

**Proposed changes to current services (if any):** One room in the hospital was verified as suitable to be used as a double room (dual-purpose) for a couple if needed. This increases overall certified bed numbers from 144 to 145 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 122

--

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Ngaio Marsh is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home and hospital level care for up to 115 residents in the care centre and rest home care up to 30 residents in the serviced apartments. On the days of the audit there were 110 residents receiving care in the care centre and 12 residents at rest home level in the serviced apartments.

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

The village manager has been in the role six years and supported by an assistant manager, and a clinical manager (registered nurse) with eight years' experience in aged care. The management team are supported by a regional manager and support staff at head office. The resident and relatives interviewed spoke positively about the care and support provided.

This audit identified no areas of improvement.

Continuous improvements were achieved around data analysis, occupational health, food services and laundry processes,

## 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.

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. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided 24 hours a day, seven days a week. Residents 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.
--	--	---

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 dual purpose and hospital units. The programme ensures the abilities and recreational needs of the residents is varied, 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. The service has a current food control plan. .

## 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.

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

The building has a current building warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on-site at all times. The environment is warm and comfortable. Housekeeping staff maintain a clean and tidy environment. All linen and personal clothing is laundered 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.

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 currently has two residents assessed as requiring the use of restraint and one resident using an enabler. 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.
---	--	--

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. 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. The service has had four outbreaks since the last audit. 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 in the nurse's stations.



## 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	48	0	0	0	0	0
Criteria	4	97	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, assistant manager, clinical manager/RN, the regional operations quality manager, and 20 clinical staff (nine caregivers who cover the rest home and hospital, three registered nurses (RNs), three-unit coordinators, the physio assistant/ health and safety representative, and four lifestyle activity coordinators) confirmed their familiarity with the Code.</p>
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. All 11 resident files (six hospital level including one resident on end of life contract and five rest home including one resident in the serviced apartment on respite care) all included written consents. General consents included the consent for photographs and sharing of medical information and also identified any specific procedures requiring consent such as catheterization's and 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</p>

to make informed choices and give informed consent.		<p>consultation with the enduring power of attorney (EPOA). Copies of EPOA and activation status where appropriate was available on the resident's 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 nine long-term resident files under the ARCC had been signed within a timely manner. There was a written agreement for the resident under end of life contract and 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. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks. Training was provided around advocacy and resident rights in November 2019.</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>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, such as shopping and maintaining links with the RSA. There is an on-site shop and hairdresser available. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. 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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a</p>	FA	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and relatives demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. Caregivers describe directing complaints to the most senior person in charge.</p> <p>There is a complaint register. Verbal and written complaints are documented. Six complaints have been lodged</p>

complaint is understood, respected, and upheld.		<p>since the previous audit in 2018. There was one rest home level complaint in 2019, two hospital in 2018, two in 2019 and one year to date in 2020. All complaints had a noted investigation, timelines determined by the health and disability commissioner (HDC) were met, and corrective actions (where indicated) were actioned. All complaints were documented as resolved.</p> <p>There have been no complaints lodged with the HDC since the previous audit.</p> <p>Complaints are linked to the quality and risk management system. The service has reviewed the complaints for trends, however there were no identifiable trends seen. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>An information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. There is the opportunity to discuss aspects of the Code during the admission process. Large print posters of the Code and advocacy information are displayed on noticeboards throughout the facility. The village manager or the clinical manager discusses the information pack with residents/relatives on admission. Residents and relatives 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>Interviews with seven residents (three rest home and four hospital) and five relatives (two rest home including one resident from a serviced apartment, and three hospital) confirmed that the services being provided are in line with the Code. The Code is discussed at resident and staff meetings.</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. 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 describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. Staff have undertaken annual training on abuse and neglect during June 2019, and privacy and dignity in September 2020 with high numbers of staff attendance.</p>
Standard 1.1.4: Recognition Of Māori	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</p>

<p>Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with the district health board Māori health directorate and through Whakamua Bicultural group. Team meetings document cultural considerations including Māori language week in TeamRyman meetings. There were no Maori residents at the facility on the day of audit.</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>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. 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. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. Cultural considerations were included in the care plan for a Muslim resident. All of the residents at the facility were able to speak and understand English. Staff have received training around cultural awareness in July 2019.</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>Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Staff job descriptions include responsibilities and House Rules.</p>
<p>Standard 1.1.8: Good</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</p>

<p>Practice</p> <p>Consumers receive services of an appropriate standard.</p>		<p>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 seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (eg, wound care, mental health) and staff education and training.</p> <p>The service has worked to improve services for residents and has implemented a number of quality programmes including improving end of life cares for residents and relatives. Ngaio Marsh identified the multi-cultural diversity within the staff mix, and recognising that culture is defined by the individual person. Cultural awareness training was provided to ensure all staff were aware of cultural practices and were unified in understanding of palliative cares. End of life, death and dying education sessions were extended for caregivers to attend. The Fundamentals of Palliative care course held through the Hospice was open for staff to attend. Te Ara Whakapiri toolkit training was provided for registered nurses (RNs) and enrolled nurses (ENs). Syringe driver workshops were provided to ensure all nurses had up to date competencies. Relatives are provided with an end of life booklet and are welcome to stay with residents during this time. There is a guard of honour with staff to give a final farewell to the resident. Staff gather with the family to watch the resident leave the facility for the last time. Training has been provided around grief and loss and caring for ourselves for all staff. Counselling sessions are free for staff who require this service. Staff have developed a good relationship with the palliative team who also provide support for grieving families. Regular meetings are held with the palliative nurses, registered nurses and relatives to discuss issues, concerns and the residents' condition. The relatives are very involved in these meetings, and have the opportunity to ask questions, and participate in care planning. The general practitioners are available for palliative residents after hours. A folder is maintained of 'thank you cards from appreciative relatives around the special care and attention received from staff of Ngaio Marsh.</p> <p>There is analysis and trending of monthly statistics of key indicators which have seen a reduction in falls, urinary tract infections, and respiratory infections (link 1.2.3.6).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<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. There was a good flow of communication evidenced throughout all of the meetings held at the facility to ensure staff are aware of information required for their role. Ryman have adopted a social media channel Chattr which as a good uptake of staff. The channel is used to inform staff of education, new information and staff can chat with each other over the site.</p>

communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ngaio Marsh is a Ryman healthcare retirement village located in Christchurch. Ngaio Marsh provides rest home, hospital (geriatric and medical) level care for up to 115 in the care centre and 30 serviced apartments. There are 63 dual purpose beds and 52 hospital beds.</p> <p>On the day of the audit, there were 37 rest home level and 24 hospital level in the dual-purpose floor, 49 hospital residents in the hospital level floor including two residents on an end of life contract, and 12 including one respite rest home residents in the serviced apartments. All other residents were on the age-related residential care contract (ARRC).</p> <p>The Ryman overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is a Ryman strategic and quality plan and a TeamRyman quality programme. There are documented quality/health and safety goals. The 'kindness culture' and 'is this good enough for my mum or dad' are themes of the service philosophy.</p> <p>The non-clinical village manager (previously a registered nurse) has been in the role for six years with previous experience in non-health related management. The village manager is supported by a clinical manager (RN) who has been in the role for two years and has previous age care experience. The non-clinical assistant manager (previous enrolled nurse) has experience as a unit coordinator in Ngaio Marsh and has been in her current role for six years. The regional operations quality manager from Christchurch head office provides support and was also present at the audit.</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>
<p><b>Standard 1.2.2: Service Management</b></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</p>	FA	<p>During a temporary absence of the village manager, the assistant manager supported by the clinical manager would perform this role.</p>

consumers.		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The TeamRyman quality and risk management programme is fully implemented. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.</p> <p>All policies and procedures, and associated documents are created and regularly reviewed by the TeamRyman Programme committee. With the introduction of VCare Kiosk many of the clinical documents have been converted to an electronic format with triggers to stimulate compliance &amp; centralised reporting to aid analysis of areas of weakness. The introduction of VCare Kiosk has driven a significant improvement in adherence to policies and procedures.</p> <p>The TeamRyman programme gives villages a monthly set of objectives and reporting requirements to ensure compliance to policies and procedures. The programme includes (but not limited to) internal audits, new policy releases or revisions, communication of objectives, reporting of statistics, etc. In addition, Ryman employs a team of internal auditors to spot audit sites.</p> <p>At service level, all data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are entered onto the electronic myRyman programme, collated and analysed with results communicated to staff and to head office. Corrective actions are implemented where benchmarked data exceeds targets. The service has exceeded the standard around data collation.</p> <p>A fully implemented internal audit programme is in place. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented.</p> <p>Annual satisfaction surveys are conducted. Overall, the 2020 resident survey identified a slight reduction of satisfaction from 4.22 out of 5 in 2019 to 4.1 out of 5 in 2020.</p> <p>Corrective actions have been implemented around activities, housekeeping, laundry services, and communication. A resident focus group has been developed to discuss the findings, quality improvement plans (QIPs) and discussing what the residents actually want to see improve with the service. QIPs were developed and implemented around table service, linen, ironing and outings. All actions have been complete and signed off with the residents satisfied with the outcomes.</p> <p>The relative's satisfaction survey was being collated and results not available at the time of the audit, however the 2019 survey identified an overall increase of satisfaction from 4.31 in 2018 to 4.37 in 2019, there was a general increase around food services, care and activities.</p> <p>Ryman's health and safety policies and procedures ensure a systemic review of all identified hazards including trend analysis to develop solutions that minimise risk. Safety is discussed at the health and safety meetings held monthly. The risk register is reviewed at the meetings and was last reviewed in September 2020. A focus of the health and safety team has been around staff wellness. The service has exceeded the standard around staff wellness and health and safety at work.</p>



		<p>Strategies are implemented to reduce the number of falls. This includes (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</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 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. Falls protocol on the myRyman system were completed for each individual fall, which includes neurological observations where required.</p> <p>A review of fifteen incident/accident forms (eight hospital, seven rest home including two from the serviced apartments), 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 during the week, providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify significant events that would be reported to statutory authorities. Section 31 notifications made include two unstageable pressure injuries in 2019. Four deep tissue injuries (facility acquired) and a resident absconding was reported in 2020.</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. Thirteen staff files reviewed; (one clinical manager, three registered nurses, four caregivers, one activities coordinator, one physio assistant/ health and safety officer, one chef, one housekeeping, and one gardener) included a signed contract, job description, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals.</p> <p>A register of registered nurse's practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice.</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. Six registered nurses (including the unit coordinators) and one enrolled nurse have</p>

		<p>completed their InterRAI training. Staff competencies are completed as relevant to the role. Registered nurses participate in two monthly RN/EN journal club which provides clinical updates and guidance. Coordinators are supported to attend the Ryman leadership training.</p> <p>Caregivers are encouraged and supported to gain New Zealand Qualification Authority (NZQA) qualifications through Careerforce.</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>	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, the assistant manager who works Monday to Friday and a clinical manager who works Tuesday to Saturday. The clinical manager, assistant manager and village manager are in addition to the rostered staffing.</p> <p>There is a unit coordinator for each unit and are included as part of the rosters.</p> <p>The Hospital unit (dual-purpose) has 52 beds. On day of audit there were 47 hospital residents and two rest home level residents.</p> <p>The hospital unit has one-unit coordinator (RN) 8am to 4.30pm Sunday to Thursday. She is supported by two registered nurses from 7am to 3.30pm. There is two interRAI days (1x eight hours and one four hours) each week.</p> <p>The nurses are supported by 10 morning caregivers who are buddied together for staff/ resident allocations; 4x 7am to 3.30pm, 1x 7am to 3pm, and 5x 7am to 1.30pm. the fluid assistant works from 9.30am to 1pm. The activities and lifestyle coordinator work from 9.30 to 4.30pm. with an extra coordinator on Tuesday and Friday from 1.30 to 3.30 to cover van outings and walks.</p> <p>The afternoon shift has two registered nurses; 1x 3pm to 11pm and 1x 3pm to 11.30pm. They are supported by five caregivers: 2x 3pm to 11pm, 1x 3pm to 9pm, 2x 4pm to 9pm and a lounge carer from 4pm to 8pm. There is one registered nurse from 11pm to 7.30am, and three caregivers on duty overnight 1x 11pm to 7.30am and 2x 11am to 7am.</p> <p>The other dual-purpose unit has 63 beds, on the day of the audit there were 37 rest home residents and 24 hospital level residents.</p> <p>The unit coordinator works from Tuesday to Saturday, a registered nurse covers on Sunday and Monday. She is supported by two registered nurses; 1x 7am to 3.30pm, and 1x 8am to 1.30 (Monday to Friday).</p> <p>There are nine caregivers on the morning shift; 2x 7am to 3.30pm, 3x 7am to 3pm, and 4x 7am to 1.30pm. the lounge assistant works from 9.30 to 1pm.</p>

		<p>The afternoon shift has one registered nurse from 3pm to 11.30pm and one senior caregiver from 3pm to 11pm. They are supported by seven caregivers: 4x 3pm to 11pm, 1x 3pm to 9pm, 1x 4pm to 9pm, and 1x 5pm to 8pm. The lounge assistant works from 4pm to 8pm. The activities and lifestyle coordinator work from 9.30am to 4.30pm</p> <p>The serviced apartments (12 rest home residents) have a unit coordinator from 7.30am to 4pm Sunday to Thursday, a senior medication competent caregiver covers this shift Friday and Saturday.</p> <p>They are supported by two caregivers from 7am to 1.30pm. The afternoon shift is covered by two caregivers (one senior medication competent) from 4pm to 10pm and one caregiver from 5pm to 8pm. The dining assistant works from 4.30 to 6.30pm. The activity lifestyle coordinator works Monday to Friday 9.30am to 4.30pm.</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 has a well-developed information pack available for potential residents/families/whanau.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term care.</p>
<p>Standard 1.3.10: Transition, Exit,</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</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>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 are stored safely in each unit. Registered nurses and senior caregiver's complete annual medication competencies and attend medication education. Registered nurses complete syringe driver training. Medication reconciliation of monthly blister packs and as required blister packs is checked by an RN with the signature on the back of the blister pack. Any errors are fed back to the pharmacy. As required medication blister packs are checked monthly for expiry dates. Hospital level impress medications are checked monthly for stock level and expiry dates. There were two rest home residents in serviced apartments who were self-medicating with a self-medicating assessment in place which had been reviewed three- monthly by the GP. The medication fridge temperatures in the dual-purpose unit and hospital unit are taken weekly and within the acceptable range. Medication room air temperatures are taken and recorded daily for the dual-purpose unit and hospital unit. There were no medications stored in the serviced apartment. All eye drops in medication trolleys had been dated on opening.</p> <p>The service uses an electronic medication system. Twenty-two medication charts were reviewed (12 hospital and 10 rest home). 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 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 nutritional needs are met where this service is a</p>	CI	<p>All food and baking are prepared and cooked on-site. The kitchen is adjacent to the dual-purpose unit dining room. There is a head chef, second chef, cooks assistant and morning and afternoon kitchenhands on duty daily. All food services staff have completed on-line food safety training. The service has continued to improve the residents dining experience including providing choice and variety of meals with the Project-Delicious four weekly seasonal menus. The seasonal menu has been designed in consultation with the dietitian at an organisational level.</p> <p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. The menu choices accommodated most dislikes and alternative options are also provided. Religious and cultural dietary requirements are met. A weekly update on dietary requirements is received from the units. Pureed meals, gluten free and vegetarian meals are identified on the menu. There are additional snacks available at all times.</p>

component of service delivery.		<p>Meals are served directly from the kitchen bain marie to residents in the dual-purpose unit dining room. Food is delivered in hot boxes to the hospital unit bain marie where the second chef serves the meals. Meals are served from the serviced apartment bain marie by the chef twice a week and by care staff at other times.</p> <p>The service has a food control plan that expires May 2021. End cooked temperatures and serving temperatures are taken and recorded. Temperatures are taken and recorded for fridges, freezer, cooking and cooling 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. Resident and relatives interviewed spoke positively about the choices and 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 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 (for all resident files) were reflected in the 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 narrative 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>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The electronic care plans for all resident files 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. A pain management plan was in place for the end of life resident. There was documented evidence of resident/family/whānau involvement in the care planning process in the files reviewed. Relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident such as the GP, physio, geriatrician, dietitian, palliative care nurse and older persons health service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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 17 wounds (six dual purpose unit, 11 hospital and one in the serviced apartment. There were two facility acquired pressure injuries in the hospital (one suspected deep tissue of sacrum and one stage 3 pressure injury of the heel). Both residents with pressure injuries were hospital level and there were section 31 notifications for each pressure injury. The service has two wound champions who review wounds weekly. The Nurse Maude wound nurse specialist has been involved in non-healing wounds. The service has adequate pressure relieving resources available.</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, repositioning charts, 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:	FA	<p>The service employs a diversional therapist (DT) and three lifestyle coordinators (one in DT training) to implement the Engage programme across all levels of care in the serviced apartments, and dual-purpose units. The</p>

<p><b>Planned Activities</b></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>programme is from Monday to Friday 10.30am to 4 pm with set activities in the weekends. There is a weekend lifestyle coordinator, caregivers and lounge carer who coordinate activities in the weekends and evenings. There are plentiful resources available. Rest home residents in the serviced apartments attend the serviced apartments programme.</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, make and create, memory lane, gardening, walks, stitch and chatter group, adult colouring, happy hour, baking, one on one pampering, beautician sessions. The knitting group make rugs for community groups. Residents are planning creations for their stall at the on-site annual market day, Themed events and festive occasions are celebrated. Community links include pre-school children, church groups, RSA, pet therapy, entertainers and guest speakers. The community centre in the serviced apartments is used for integrated activities such as boccia challenge, indoor bowls, bible study, church services, entertainers and moves. There are weekly van outings/scenic drives for all residents. A wheelchair taxi is hired for hospital level residents. The van drivers and activity team have current first aid certificates. The men's group enjoy guest speakers, watching sports, vintage cars and a beer and pie afternoons.</p> <p>The activity team shared photos with families during lockdown and arranged zoom meetings with families and the 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 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 resident and relative meetings and surveys. The residents and relatives interviewed stated they were very satisfied with the activities offered.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Nine long-term files identified that the initial assessment had been evaluated 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, physiotherapist, 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 notified of the outcome of the review if unable to attend. Care plans had been updated with any changes to health and care. 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 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, hospice 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 are implemented policies to guide staff in waste management: Staff interviewed were aware of practices outlined in relevant policy. Relevant staff have completed chemical safety training. Gloves, aprons, and goggles were available for all care staff and in sluice rooms and laundry/housekeeping areas. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing while carrying out their duties. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets and product information is available. The chemical provider monitors the effectiveness of chemicals and provides chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	FA	<p>The building has a current warrant of fitness that expires August 2021. The care centre is across two levels with the dual-purpose unit (rest home/hospital) on level 1 (ground floor) and the hospital unit on level 2. The 30 serviced apartments for rest home level are across two levels.</p>



<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>The head maintenance person works full-time and has completed chemical safety training, safe manual handling and infection control education and is on the health and safety committee. He is supported by a village support person who assists with maintenance and the setting up for functions in the community centre. There is a maintenance register used for day to day repairs and signed off as these are addressed. Essential contractors are available 24 hours.</p> <p>The planned maintenance schedule includes 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. Two 12-seater vans have current warrant of fitness and registrations.</p> <p>There have been ongoing refurbishments including re-carpeting, painting, new furniture in dining and lounge areas, new smart TVs in all lounges and new outdoor seating.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space in the dual purpose (rest home/hospital) and hospital unit for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. One room in the hospital was verified as suitable to be used as a double room for a couple. The room has two call bells and there is sufficient space to manage mobility equipment.</p> <p>There is a separate gardening and grounds team. The grounds and gardens are well maintained, and the team have received gardening awards. Residents are able to access outdoor areas and internal courtyards and atriums safely or with supervision.</p> <p>Staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including full hoists, standing hoists and pressure relieving resources.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene</p>	<p>FA</p>	<p>All resident rooms (including the serviced apartments) have full toilet/shower ensuites. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Non-slip flooring and handrails are in place. Care staff interviewed confirmed they maintain the resident's privacy when undertaking personal cares.</p>

requirements.		
<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	<p>There is one double room for a couple in the hospital unit. All other resident rooms are single. All bedrooms and ensuites are spacious for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The hospital unit has a large open-plan dining area and open plan lounge area. Seating is arranged to allow large group and small group activities to occur. There are two smaller family rooms. One family room has tea making facilities and a resident phone. There is a seating area above the main reception area with views of the atrium where hospital level residents can enjoy entertainment and musicals held in the atrium.</p> <p>The dual-purpose (rest home/hospital) unit has a separate dining room, large lounge and a smaller family room with tea making facilities and a resident phone. There are many seating alcoves throughout the facility.</p> <p>All serviced apartments also have their own spacious lounge and kitchenette as well as communal dining areas. There is a serviced apartment dining room and separate lounge area. Communal areas on the ground floor are available to all residents including the hairdressers, shop, beauty therapy room and library.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	CI	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The laundry is located in the service area on the ground floor. The laundry has an entry and exit door with defined clean/dirty areas. All linen and personal clothing is laundered on-site. There are two laundry staff who work between 8am to 4.30 pm and an afternoon person from 7pm to 10pm. There are large commercial washing machines and dryers which are serviced regularly. The service has been successful in reducing missing and/or shrinkage of delicate clothing items. Air conditioning was installed in the laundry last summer.</p> <p>There are dedicated cleaners from 8.30am to 4.30am seven days a week. One cleaner is allocated to daily additional cleaning tasks including the wiping down of all door handles and frequently touched surfaces. The cleaning trolleys are well equipped and cleaning staff carry chemicals in a caddy into resident rooms. The cleaning</p>

provided.		<p>trolleys are kept in locked cupboards when not in use. There is a measured mixing system for the refilling of chemical bottles.</p> <p>Cleaners and laundry staff were observed wearing appropriate protective clothing while carrying out their duties. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas.</p> <p>Feedback is received through resident meetings, surveys and results of internal audits.</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 policies in place to guide staff in managing emergencies and disasters. Emergency management and fire evacuations drills are included in the mandatory in-service programme. A non-fire emergency training was held to prepare staff in the event of a disaster. There is a first aid trained staff member on every shift. The village has an approved fire evacuation plan and fire drills occur six-monthly, last in August 2020. There are sufficient supplies of food, water and equipment for at least three days. The service has a generator and BBQ for cooking. There are emergency civil defence kits in each nurse's station.</p> <p>There is an effective call bell system in all bedrooms, ensuites and communal areas. The call bells and door alarms are linked to pagers carried by staff. Calls light up on the main call panel in the nurse's station. The facility is secure after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There are diesel wall heaters which can be individually adjusted. Internal resident rooms have doors that open onto the atrium which allows for plenty of natural light through the glass roof. All external rooms have an opening window. There is an air exchange system in place. There is plenty of natural sunlight and ventilation. The upstairs hospital lounge has opening doors onto a small balcony for ventilation.</p>
<p>Standard 3.1: Infection control</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. The clinical manager</p>

<p>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>	<p>is the infection control officer. The infection prevention and control coordinator's job description is included within the clinical managers job description. The infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet 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. Ngaio Marsh has developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB.</p> <p>The Ryman team identified early in 2020 that coronavirus was becoming more prevalent and a plan was required to manage the potential for an outbreak. The safe haven project was implemented. Staff, residents and relatives were updated with the changes required to the village and infection control processes as soon as new information was available. Signage was posted at the front entrance to remind visitors of cough etiquette and infection control measures including the use of hand gels and handwashing. The management team were liaising closely with the Ryman Christchurch team</p> <p>When during the lockdown period, physical distancing was in place for resident activities and meals, staff wore masks, staff changed into their uniforms at work. Staff were restricted to their own work 'bubble' with each bubble having separate areas for breaks and changing. Competencies around hand hygiene was completed, and screening tools for staff and residents were maintained. Cabins were supplied for extra security staff required during the levels 4 and 3 lockdown period. Only the main entrance was used to track all staff. Other entrances were available in the use of emergencies with locks changed to the doors were open from the inside (in case of emergency) but locked from the outside. Showering areas were available for staff. There were deliveries of personal protective equipment (PPE) and hand sanitizers in the case of a pandemic. There was an increase of oxygen supplies, and an additional concentrator was supplied. Additional rows were entered onto the roster to ensure coverage in the event of an outbreak. Staff were recruited to these roles on fixed term contracts. Daily updates with staff occurred via the Chattr channel, and companywide webinars were attended by management with the wider Ryman teams. Residents were updated daily and required to isolate in their rooms for the duration of level 4 lockdown, any resident with symptoms was isolated for 14 days. Relatives were updated of any changes and were able to communicate via zoom (appointment system).</p> <p>Education sessions were held in March with a microbiologist, education sessions were held around Covid19, and the flu. Competencies were completed with 100% pass for PPE and handwashing. The emergency pandemic plan was implemented as per Ryman instructions. Staff 'bubbles' at work and home, including all members of staff who were working were identified. Staff were offered accommodation in town houses and paid if they had to isolate for 14 days. Zoom was available in all resident rooms available by appointment so relatives and residents could maintain contact. Activities and exercises were performed in the corridors.</p> <p>The service continues to monitor stocks of PPE and maintain wellness declarations for all visitors entering the facility. Covid e-learning has been completed in June 2020 by all staff including non-clinical. Chemicals were reviewed and there is a housekeeper dedicated to high touch areas. Residents interviewed commented on the comfort this provides. All new admissions required a negative Covid-19 test prior to consideration and were still required to isolate for the required 14 days. GPs were well updated via emails around changing requirements.</p>
---	---

		<p>Relatives with residents at the end of their lives were allowed to visit with strict infection control measures in place. An emergency response guideline was launched to help with preparedness in the event of a pandemic. A “Go Kit” was made available in the Covid sharepoint page. The kit clearly explains the details required from the first 30 minutes of a positive case. There are staged instructions for setting up the kit immediately if required. Covid19 continues to feature at the weekly leadership meetings. A glow light is used for high touch area monitoring, electronic wellness declarations remain in place. Covid-19 leave is still available if required. Covid-19 virtual tours and drills have occurred to ensure preparedness. Emails were sighted from relatives congratulating and thanking the staff for their great work during the Covid-19 period. Relatives interviewed felt the staff did an ‘outstanding job’ during the lockdown, they felt well updated and were reassured by staff to call at any time if they wished. The residents interviewed, felt they were kept up to date with newsletters, the previous newsletter was removed so residents only had up to date information. Staff interviewed were well versed on procedures around PPE, hand sanitizer, and isolation protocols. All staff interviewed appreciated the hampers and wellness checks provided</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator is new to the role, and the clinical manager has maintained best practice by attending infection control updates. The infection control team is representative of the facility. Resident care plans reviewed included comprehensive documentation for any known infections. An example is one resident with shingles. The care plan described required interventions and staff demonstrated good knowledge of the care needed for this resident.</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>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</p>	FA	<p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. Policies and procedures, and the Pandemic plan have been updated to reflect Covid-19.</p>

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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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. Education sessions have been held around Covid19 in March and a Covid-19 outbreak drill was held in September 2020.</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>	FA	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator who is a registered nurse. The registered nurse is directly responsible to the clinical manager.</p> <p>An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the infection prevention and control (IPC) and the weekly leadership meetings. Each individual infection is discussed at the leadership meeting to determine the source. All meetings held at Ngaio Marsh include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation.</p> <p>There have been four outbreaks at the facility since the last audit. One was confirmed as norovirus, one human metapneumovirus and two were not identified. All were reported and managed well. The laundry person interviewed was very knowledgeable regarding cross infection and laundry needs for infectious linen. The service has reduced the incidence of urinary tract and respiratory infections (link 1.2.3.6).</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There was one resident using an enabler and two hospital level residents using restraints during the audit. The resident file was reviewed where an enabler was in use. Voluntary consent and an assessment process had been completed. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is a registered nurse with 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. The approval group meets six-monthly and all restraint and enablers are reported to TeamRyman monthly.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, approval group, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two residents' files with restraint use were reviewed. Completed assessments considered those listed in in 2.2.2.1 (a) - (h).</p>

to use of restraint.		
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialed before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator/approval group. The use of restraint and risks identified with the use of restraint was linked to the two resident care plans reviewed, the level of risks were identified and well documented in the care plans. Internal audits conducted, measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on the myRyman system, as evidenced in two residents' files where restraint was in use.</p> <p>A restraint register is in place providing a record of restraint and enabler use. This is completed for all residents requiring restraints and enabler.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment for the residents on the restraint register, and six-monthly as part of the care plan review. Families are included in the review of restraint use. Files reviewed for residents with restraint use evidenced that evaluations were up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator and members of the approval group. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme, and staff education and training and review. Benchmarking around restraint indicates Ngaio Marsh is well below the benchmarking range</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
--------------------

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The achievement of the rating that service provides an environment of ongoing quality initiatives is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. The leadership team	<p>A log is maintained of all incident reports and current wounds. All ongoing wounds and individual incidents are discussed to look at the whole picture including the resident's health conditions, the current care plan, environment, staff education, staff skill mix, and QIPs in place to minimise further incidents. All new incidents, infections and wounds are discussed to determine “why” residents are experiencing infections, or incidents such as falls.</p> <p>As a result of the extra discussions and monitoring performed, the service has reduced urine infections from 4.61/1000 bed nights in 2019 to 0.29/1000 bed nights in August 2020. Respiratory tract infections were monitored closely especially with Covid 19. Education was provided as ministry of health guidelines. Flu vaccines had 127 resident and 128 staff uptake in 2020. The respiratory tract infections have dropped to 0.61/1000 bed nights in 2020. There have been no respiratory infections in July and have remained significantly low in August 2020.</p> <p>The clinical manager and leadership team also monitor falls very</p>

		meet weekly. During the meeting, the quality data is discussed, as part of the agenda.	closely. A review of falls at hospital level showed an increase in April 2019 to 14.99/1000 bed nights. Falls continue to be discussed at the leadership meetings, with fall prevention strategies reviewed, and the residents underlying conditions considered. The falls assessment tool is completed, and falls protocols are monitored and followed up post falls. The clinical manager reviews the call bell report daily, and copies are provided to the unit coordinators. Any incidents with call bells not answered within eight minutes are asked to complete a written explanation which is kept on file. The physiotherapist review changes in resident mobility and a lounge carer is in the lounge monitoring residents. Residents at risk of falling are encouraged to join the exercise programme. Falls and incidents are discussed at the handovers between shifts to ensure staff are up to date with current information. Falls have reduced to 4.32/1000 bed nights in August 2020 at hospital level care and 2.39/1000 bed nights at rest home level care in August 2020 from 9.65/1000 bed nights in December 2019.
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service</p>	CI	Ngaio Marsh health and safety committee have had a focus on staff wellness to include diet, activity and prevention of injuries as part of the Village objectives.	<p>There was an increase in resources available to staff relating to general health, wellness and wellbeing.</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</p>

provision is developed and implemented.			<p>to say “thank-you”. A concierge service was made available to the unit coordinators and managers.</p> <p>Staff continue to be encouraged not to come to work if they are unwell. Additional sick leave has been provided, so staff feel 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. The Chattr Channel has been well received by staff.</p> <p>Staff were provided with wellness journals to document healthy diet and exercise daily, and smoke free packs and support have been offered to staff. The facility is aiming to be smoke free by 2025. Each staff member has been allocated a wellness day. Seventy-three staff have taken their wellness day since it has been allocated.</p> <p>Since the improvements and focus on staff wellness, there has been a reduction in staff work related back injuries from 3 in 2019 to 1 in 2020 (to date).</p> <p>The storage rooms are tidy and organised (as sighted during the audit) and the staff interviewed commented on the work done to the equipment room, reducing stress, injuries and equipment being readily accessible.</p> <p>There has been a 96% uptake from staff around the Chattr channel, with general activity on the site around 83%. The channel is used by managers to remind staff of competencies, education, any changes and reminders to staff. Staff comments include “thanks” for the hamper for international nurses’ day, suggestions for books staff have been reading, and general comments of encouragement.</p> <p>There was an increase in the staff satisfaction survey with the net promoter score raised from 27 in 2019 to 58 in 2020. The staff interviewed all stated they ‘loved’ working at Ngaio Marsh, they felt appreciated and felt they had a good team. This was also evidenced in meeting minutes.</p>
Criterion 1.3.13.1 Food, fluid, and nutritional	CI	The service has implemented the project-delicious over the last two years and has continued to	Project “delicious” 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 meals were

needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.		improve the variety, choice and quality of meals provided. The resident and relative survey evidence there has been an increase in meals satisfaction.	observed to be well presented and residents interviewed stated there was plenty of choice and they enjoyed the meals. The use of pure foods adds nutritional value to pureed/soft meals and is also used as a base for soups, smoothies and desserts. The food services staff are accessible and visible in dining rooms facilitating direct feedback/suggestions on meals. There is a six weekly fine dining at the chefs table that includes a small group of residents and relatives each time. There is a fortnightly chef's choice on the menu. The food services are involved in catering for resident happy hours, special events and functions. The relative survey for food in 2019 was 3.65 which increased to 4.07 in 2020. The resident survey was 3.64 in 2019 to 3.92 in 2020.
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	A quality improvement regarding the laundering of delicate and woollen clothing was identified following a relative survey August 2019. The service implemented an action plan to improve the laundering of delicate and woollen clothing. The relative survey February 2020 demonstrated an increase in satisfaction with laundry services.	<p>The assistant manager in consultation with laundry staff searched for an alternative way to label delicate and woollen clothing to easily identify the laundering procedure and reduce shrinkage. A company was sourced, and several trials were completed before the correct type of label was found. Red labels are printed with either "delicate" or "handwash". Residents clothing was relabelled with the appropriate label. All new clothing is taken to the laundry for appropriate labels. The new labels ensure woollens are handwashed and line dried and the delicate items are washed on the delicate cycle. The laundry staff stated it was so much easier to identify the washing process required for clothing when sorting the residents personal washing in their purple laundry bags, as they arrive in the laundry. There have been no resident/relative complaints regarding shrinkage of woollens. Resident meeting minutes (October 2020) document the laundry is excellent and there were no concerns. The August 2019 relative survey for laundry services was below the Ryman average score. The relatives survey result for 2020 was 4.35. The service has been successful in reducing shrinkage of delicate items and woollens.</p>

End of the report.