

Diana Isaac Retirement Village Limited - Diana Isaac 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:	Diana Isaac Retirement Village Limited
Premises audited:	Diana Isaac Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 November 2020 End date: 10 November 2020
Proposed changes to current services (if any):	Two dual purpose resident rooms in the rest home unit and two dual purpose rooms in the hospital unit were assessed as suitable for double occupancy. Occupancy is limited to either two rest home residents

or one rest home and one hospital level resident in the double rooms. This increases the total number of beds in each unit from 40 to 42. The total available beds in the care centre increase from 120 to 124 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 124

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

Diana Isaac is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital, and dementia level care for up to 164 residents. This includes 124 beds in the care centre and 40 serviced apartments certified to provide rest home level care. This audit included verifying four rooms (two in the rest home unit and two in the hospital unit) as suitable to be used as double rooms as needed for couples. On the days of the audit there were 124 residents including 5 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.

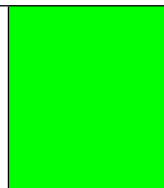
The village manager (non-clinical) had been in the role sixteen months and supported by an assistant to the manager, and two clinical managers (registered nurses). The management team are supported by a regional manager and support staff at head office. The resident and relatives interviewed spoke positively about the care and support provided.

This audit identified the service fully met all the standards.

Continuous improvements were identified around reducing quality initiatives and unintentional weight loss.

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.

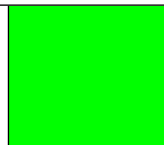


Standards applicable to this service fully attained.

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 both clinical managers 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. The resident and relatives 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.		Standards applicable to this service fully attained.
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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, were individualised and evaluated six-monthly. The general practitioner reviews residents on admission and at least three- monthly. Other allied health professional are involved in the care of residents including (but not limited to) the physiotherapist and dietitian.

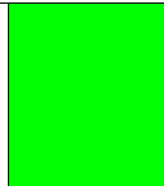
The activity team implement the Engage activity programme in the rest home/ hospital and dementia units that ensures the abilities and recreational needs of the residents is varied, interesting and involves entertainers, outings and community visitors.

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. There are nutritious snacks available 24 hours in the dementia unit.

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.

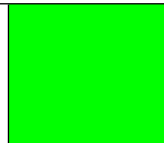


Standards applicable to this service fully attained.

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 ensembles. 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 and internal atrium 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 restraint coordinator maintains a register of restraints and enablers in use. The service currently had four residents requiring the use of restraint, and no residents using enablers.

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 are 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 outbreaks in 2019, and 2020, which were well managed, logs were maintained, and appropriate notifications made. COVID-19 19 lockdown was well managed, and precautions remain in place as per current guidelines.

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	0	50	0	0	0	0	0
Criteria	2	99	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code).</p> <p>Discussions with the village manager, assistant manager, both clinical manager/RN, regional operations manager, and 25 clinical staff (13 caregivers who work across the facility, four unit coordinators (three registered nurses and one enrolled nurse), five registered nurses (RNs), and three diversional therapists) confirmed their familiarity with the Code. Non-clinical staff including two laundry staff, one van driver (health and safety rep), one physiotherapist (contracted), lead chef, two housekeepers and a maintenance person interviewed were also familiar with the Code. The Code is discussed at resident and staff meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to</p>	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. General consents were sighted in the 12 files reviewed (four hospital level including one resident on end of life contract, four rest home including one resident in the serviced apartments and one resident on respite care and four dementia care files). Specific consents were viewed for wound photographs and influenza vaccines. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Informed consent training was held Feb 2019.</p> <p>Resuscitation status was signed by the competent resident and witnessed by the general practitioner (GP).</p>

<p>make informed choices and give informed consent.</p>		<p>Where the resident is unable to make a decision, the GP makes a medically indicated not for resuscitation in consultation with the enduring power of attorney (EPOA). The EPOA for the four-dementia level of care residents had been activated. Copies of EPOA and activation status are available on the resident's files.</p> <p>Advance directives where completed were available on the resident files. Advance directive/ resus/ advance care planning training was held March 2020.</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 10 long-term resident files under the ARCC had been signed within a timely manner. There was a short-term agreement in place for the respite care resident. There was a DHB agreement for end of life funding for the palliative 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>	<p>FA</p>	<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. The caregivers and registered nurses interviewed can describe instances where an advocate would be required and were aware of where this information is held. Training around advocacy was held 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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting as current COVID-19 19 regulations allow. 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. A range of entertainers, schools and kindergartens visit the facility as COVID-19 19 regulations allow, there are regular van outings to places of interest. There is an on-site hairdresser available. 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 complaint is understood, respected,</p>	<p>FA</p>	<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 the resident and relatives demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Ten complaints (four verbal and six written) in 2020 (year-to-date), three in 2019</p>

and upheld.		<p>and two in 2018 since the previous audit were lodged.</p> <p>Verbal and written complaints are documented. All complaints had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned. All complaints were documented as resolved. 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. Training sessions around the complaints process has been held annually, (last held in July 2020).</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. Interviews with five residents (one hospital level and four rest home) and eight relatives (three rest home, two hospital, and three special care unit) confirmed that the services being provided are in line with the Code, and that information around the Code had been provided to them. A training session on the code of resident rights/ responsibilities and advocacy was last held in November 2019.</p> <p>Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager or the clinical manager discuss the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and family members 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 with very good attendance, and privacy and dignity was held in September 2020 also with a high attendance of 75 staff. Caregivers interviewed showed a good understanding of the different types of abuse and neglect and signs and symptoms residents may present and could easily describe maintaining residents' privacy and dignity.</p>
<p>Standard 1.1.4: Recognition Of Māori</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care</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>planning and visiting is encouraged. Links are established with the local iwi Tuahiwi who are available for residents and as a support to the village for any Māori related advice and the blessing of rooms. On the day of the audit, there was one Māori resident. The Maori health plan incorporated the resident's cultural preferences. Team meetings document cultural considerations including Māori language week in TeamRyman meetings.</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. The resident 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. All residents at the facility were able to speak and understand English. Cultural awareness, and resident values training was last held in May and July 2020 with almost 100 staff attending.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers, nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries in respect of gifts.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three- yearly. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>Registered nursing staff are available 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>

		The service has worked to improve services for residents and has implemented a number of quality initiatives as a result of satisfaction surveys, and monthly analysis of quality data. A quality project was implemented around reducing unintentional weight loss (link 1.3.13.1 CI).
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>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. There is an interpreter policy in place and contact details of interpreters were available. A quality improvement was initiated to ensure the residents and relatives felt they were communicated with following the satisfaction survey results. An education session around communication was held in 2019. Monthly newsletters are sent to relatives, and there is Village connections updates monthly. Staff ensure relatives are notified as soon as practical if there are changes or incidents occur. The relatives interviewed stated the service was very prompt at notifying them of any changes or updates. Power point presentations have been implemented with photos of residents participating in activities. There is a team approach to communication to ensure all members of the clinical and non-clinical teams are kept informed, and report changes they notice in residents. The resident 2020 satisfaction survey evidenced a slight increase in satisfaction from 4.23 in 2019 to 4.24 in 2020. The relative satisfaction survey evidenced an increase from 4.46 in 2019 to 4.54 in 2020.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Diana Isaac retirement village provides care for up to 120 residents at hospital, rest home and dementia level care in the care centre and up to 40 residents at rest home level care in serviced apartments. On the day of audit there were 124 residents in total, including five rest home level of care residents (two respite) in the serviced apartments. In the care centre, one resident was on an end of life contract, and there was one rest home resident on respite.</p> <p>This audit also included verifying two double rooms on the rest home floor and two double rooms on the hospital floor as suitable to be used by a couple. This increases the total number of beds from 120 to 124 in the care centre. One of the double rooms in the rest home was occupied with a married couple (one rest home and one hospital level care). The RN attends to this resident when no RN available in the RH.</p> <p>All 40 rooms in the rest home (ground floor/level 1) and the 40 rooms in the hospital (level 2) are dual-purpose. There were 40 rest home residents and one hospital resident on the ground floor/level one (41 of 42). There were 39 (of 42) hospital level residents on level two. The dementia care units (two 20-bed units) are on level three. Unit one has 20 residents and unit two has 19 residents. The units are staffed and operated as two separate units.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are translated</p>

		<p>at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific village objectives 2020 and progress towards objectives is updated as part of the TeamRyman schedule. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and dementia care.</p> <p>The village manager at Diana Isaac is non-clinical, has been in the role for sixteen months and has a background in non-health care related management. She is supported by two clinical managers who are both registered nurses. One clinical manager works four days a week, and has been in the role for 14 years, and the second clinical manager works three days a week and has been in the role for four and a half years. Both clinical managers are onsite Mondays and Wednesdays.</p> <p>The assistant manager (non-clinical) has been in her role for eight years and supports both the village and clinical managers in their roles. There are experienced unit coordinators in each area (registered nurses in the rest home, hospital and dementia care units and an enrolled nurse in the serviced apartments). The team are also supported by a regional operations manager who was present during the audit. Ryman provide ongoing training for managers and clinical managers. The village manager has attended management masterclasses through Ryman and a Ryman village manager day. The clinical managers have attended leadership training days through Ryman, which included challenging conversations and team building.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the temporary absence of the village manager, the assistant manager supported by both clinical managers would cover the manager position. The regional manager would be available for support if required.</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</p>	<p>FA</p>	<p>Diana Isaac has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance are reported at the weekly management meetings and also to the organisation's management team. Quality data, quality initiatives and corrective action plans are discussed at the monthly full facility meetings, clinical meetings and other facility meetings held across the site. Meeting minutes are made available to staff. Discussions with the managers and staff and review of management and staff meeting minutes, demonstrated their involvement in quality and risk management activities.</p>

<p>that reflects continuous quality improvement principles.</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 the health and disability standards. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in staff meeting minutes and staff interviews.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There is an internal auditing programme set out by head office. The facility manager and assistant manager completes or delegates staff to complete non-clinical audits and the clinical managers or registered nurses/ unit coordinators complete clinical audits. The service develops a corrective action plan for any audit result below 90%. A quality improvement plan (QIP) register is maintained. Corrective actions are signed off when completed and audit results are communicated at the management and facility meetings</p> <p>The facility has implemented processes to collect, analyse and evaluate data including resident and staff accident/incidents, hazards, infections, complaints, surveys and audit outcomes, which is utilised for service improvements. Quality improvement plans have been developed for areas identified for improvement including (but not limited to); improving resident satisfaction with care, food services, enhancing laundry and housekeeping services, reducing urinary tract infections, reducing aggressive behaviours, improving communication with residents and relatives and retention of staff. The service has exceeded the standard around quality data analysis resulting in the reduction of challenging behaviours.</p> <p>Resident and relative surveys are completed annually. Care centre resident survey results for 2020 showed overall satisfaction, with an average score of 4.30 out of 5.0 (up 0.16) from 2019. The service was ranked 25 out of 33 (up five places from 2019). There was increased satisfaction around laundry and housekeeping, food services, and the environment. Communication and activities were relatively unchanged from 2019. The relative's satisfaction survey had an average score of 4.26 out of 5.0 a slight increase of 0.04 from 2019. A quality improvement plan has been developed around activities with a decrease in satisfaction of 0.01. The results and QIPs are discussed at all meetings.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee (the management team, unit coordinator, chef, gardener, maintenance, the fire safety person (DT), and the van driver). The van driver (interviewed) has been in the health and safety committee for five years and has completed level 1 and 2 external training. Ryman have initiated "stop and think" cards that are completed following every incident to analysis and identify the root cause. The noticeboard keeps staff informed on health and safety meetings. Ryman head office sends out health and safety bulletins regularly and alerts for staff information and awareness. The hazard register was last reviewed in August 2020, and new hazards are discussed at the monthly meetings. Training sessions on hazard, incidents and accident reporting was last held in June 2020. Current initiatives include promoting staff awareness of working in a safe environment and 'step back' cards are ongoing.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contract a</p>
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		<p>physiotherapist 20 hours a week who is supported by an employed physiotherapy assistant to carry out exercises and walks as directed by the physiotherapist. Caregivers interviewed could describe falls prevention strategies as documented in myRyman care plans.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded 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. Neurological observations were completed for all unwitnessed falls and where there was the potential for a head injury. The incident reports reviewed document opportunities to minimise future risks.</p> <p>A review of fifteen electronic incident/accident forms for the facility identified that all were fully completed and include timely follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings, providing an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify significant events that would be reported to statutory authorities, this has included notification of the outbreaks in 2019 and 2020, and section 31 notifications in 2019 for absconding residents, one non facility acquired unstageable pressure injury and two stage 3 facility acquired pressure injuries in 2020. Reports are sent to head office, who also advise on notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. There is a total of 174 staff, the service is currently recruiting extra staff to cover the holiday period.</p> <p>Fourteen staff files reviewed; (one clinical manager, two unit coordinators, one registered nurse, seven caregivers (including four senior caregivers who administer medications), one diversional therapist, one housekeeper, one laundry assistant) 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</p>

		<p>for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Thirteen of 24 registered nurses and one clinical manager have completed their InterRAI training. 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. All staff have completed the core competencies relevant to their role, with 101 staff completing the infection control competency in 2020.</p> <p>There are 26 staff who work in the dementia units, 23 staff have completed the required dementia standards, 11 of these have also completed the four-unit standards. Two staff are in the process of completing the standards and one staff member has recently been employed. There are 14 other staff in the facility who have completed the dementia unit standards, who can be called on to provide cover if required.</p> <p>There is a total of 74 caregivers, who are encouraged to participate in New Zealand qualification authority (NZQA). Currently there are nine caregivers with level 4, three with level 3, and eight with level 2 NZQA. There are nine caregivers who are internationally trained registered nurses. Twenty-one caregivers have completed National certificate Core Competencies, seven have the residential component.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The service staffing includes.</p> <p>A village manager who works Monday to Friday, the assistant to the manager who works Monday to Friday and two clinical managers who cover Monday to Sunday. The clinical manager, assistant to the 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>Dementia care unit one (20 residents) morning shift: One unit coordinator Mon- Friday across both units; Caregivers: 1x 7am to 3.30pm and 1x 7am to 1.30 pm, activities from 9.30am to 6pm shared between the two units, and a lounge assistant from 9am to 5pm (shared across the two units).</p> <p>Afternoon shift: Caregivers - 1x 3pm to 11pm and 1x 3pm to 9pm, and a lounge assistant from 4pm – 8pm (shared across the two units).</p> <p>Night shift: one senior caregiver who is medication competent 10.45 pm to 7.15 am (shared across the two units), and 1x 11pm to 7am.</p> <p>Dementia care unit two (19 residents): Morning shift: Caregivers - 1x 7am - 3.30pm and 1x 7am - 1.30pm, activities from 9.30am to 6pm (across the two units), and a lounge assistant from 9am to 5pm (shared across the two units).</p>

		<p>Afternoon shift: Caregivers - 1x 3pm - 11pm, and 1x 3pm to 9pm, and a lounge assistant from 4pm to 8pm (shared across the two units).</p> <p>Night shift: one senior caregiver who is medication competent 10.45 pm to 7.15 am (across the two units), and 1x 11pm to 7am.</p> <p>Staffing in the rest home unit (41 residents) on the day of the audit include: a unit coordinator (RN) Sunday to Thursday, and a registered nurse seven days a week from 7am to 3.30pm.</p> <p>They are supported by four caregivers: 1x 7am to 3.30pm, 1x 7am to 3pm, 1x 7am to 1.30pm and 1x 7am to 1pm.</p> <p>The afternoon shift has four caregivers; 2x (one of whom is an enrolled nurse or medication competent senior caregiver), 1x 4pm to 9pm and 1x 5pm to 8.30pm.</p> <p>The night shift has one senior caregiver 10.45pm to 7.15pm and one caregiver from 11pm to 7am.</p> <p>Staffing in the hospital unit (39 residents) on the day of the audit include: the unit coordinator (RN) Tuesday to Saturday. Two registered nurses on morning and afternoon shift and one registered nurse on night shift. One RN on afternoon shift and on the night shift oversees the rest home, serviced apartments and dementia care unit. There are two allocated days per week for nurses to catch up on interRAI assessments and care planning.</p> <p>They are supported by eight caregivers and a fluid assistant: 1x 7am to 3.30pm, 3x 7am to 3pm, 2x 7am to 1.30pm, 2x 7am to 1pm and 1x fluid assistants from 9.30am to 1pm.</p> <p>The afternoon shift has six caregivers and a lounge caregiver: 2x 3pm to 11pm, 3x 3pm to 9pm, 2x 4pm to 9pm, and one lounge caregiver from 4.30pm to 8.30pm.</p> <p>Night has three caregivers from 11pm to 7am.</p> <p>Staffing in the serviced apartments include; The unit coordinator (enrolled nurse) works from Tuesday to Saturday from 8.30am to 4pm, a senior caregiver covers Sunday and Monday. There are two caregivers rostered on the morning shift; 1x 7am to 3pm, 1x 7am to 1.30pm and a dining assistant from 9.30am to 1.30pm.</p> <p>The afternoon shift has one senior caregiver (medication competent) from 4pm to 9pm and a caregiver from 4.30pm to 7pm.</p> <p>It was reported that the staff from the rest home area cover the serviced apartments and townhouse call outs from 8pm to 7am.</p> <p>On the days of audit, staff on duty were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. The resident and relatives interviewed reported there are adequate</p>
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		staff numbers to meet resident needs.
<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	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. The resident files were appropriate to the service type. 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>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 an information pack available for residents/families/whānau at entry including specific information on dementia level of care and the safe environment.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service 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>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	FA	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 education. Registered nurses complete syringe driver training. Medication reconciliation of monthly blister packs and as required blister packs are checked by an RN with the signature on the back of the blister pack. Any errors are fed back to the pharmacy. Hospital level impress medications are checked weekly for stock level and expiry dates. There was one hospital level resident self-medicating

<p>legislative requirements and safe practice guidelines.</p>		<p>(inhalers) with a self-medicating assessment in place that had been reviewed three-monthly by the GP. The medication fridge temperatures are taken weekly in all units and are within the acceptable range. Medication room air temperatures are taken and recorded daily. All eye drops in use were dated on opening.</p> <p>The service uses an electronic medication system. Twenty-four medication charts were reviewed (eight hospital, eight rest home and eight dementia care). All medication charts had photographs and allergies documented. Medication charts had been reviewed at least three-monthly by the GP (except for respite care residents). Records demonstrated that regular medications were administered as prescribed. As required medications had the indication for use documented. The effectiveness of as required medications was recorded in the electronic medication system and in the progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food and baking are prepared and cooked on-site. The kitchen is located in the service area on the ground floor. The lead chef (interviewed) is supported by an evening chef, cook assistants, morning and afternoon kitchenhands each day. An additional cook assistant does baking once a week. All food services staff have completed food safety on-line training and chemical safety.</p> <p>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 seasonal menu has been designed in consultation with the dietitian at an organisational level. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes including weight loss. Dislikes are accommodated. Pure foods are used for pureed meals and as a base for soups and other suitable foods. Lip plates are available to encourage resident's independence with meals. Meals (in bain marie dishes) are delivered by hot boxes to the units where the meals are served by a kitchen staff member and dining assistant in the unit. Special diets are plated and labelled in the kitchen. Nutritious snacks such as sandwiches, muffins, fruit and yoghurts are delivered to the dementia care unit daily and there was plenty of snacks, fluids and foods available in all the units. Each unit has a functioning satellite kitchen from where the breakfast is served.</p> <p>There is current food control plan issued January 2020. Temperatures are taken and recorded for fridges, freezer, cooking and cooling and incoming goods. All foods were stored correctly, and date labelled. The chemicals are stored safely, and the chemical provider conducts checks on the dishwasher regularly. 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 resident survey result for food services had improved from February 2019 at 3.62 to 3.96 in February 2020.</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>	<p>FA</p>	<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>	<p>FA</p>	<p>In the files reviewed, an initial assessment and relevant risk assessment tools had been completed on admission for all residents including the respite care resident and end of life resident. The outcomes of interRAI assessments and triggers for long-term residents were reflected in the long-term care plans reviewed. Additional assessments such as (but not limited to) behavioural, pain, wound and physiotherapy assessments were completed according to need. There were ongoing pain assessments for the end of life resident. 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 evaluation. 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>	<p>FA</p>	<p>The care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met in all 12 resident files reviewed. 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. There were behaviour management plans in place for the four dementia care resident files reviewed. There was a comprehensive pain management plan in place for the end of life resident. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Relatives interviewed confirmed they were involved in the care planning process and signed the care plan acknowledgment form (kept in hard copy files). Other information gathered from allied health professionals and discharge summaries are used to develop care plans. Care plans included involvement of allied health professionals in the care of the resident such as the GP, physio, geriatrician dietitian and palliative care nurse. This was integrated into the electronic myRyman individualised record.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The 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 visit or nurse specialist consultant. 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 electronic work log.</p> <p>Wound assessments, treatment and evaluations were in place for 17 wounds (four rest home, seven hospital and six dementia care). There were skin tears, blisters, scratches, chronic leg ulcer and one surgical wound. One non-facility acquired stage 1 of the buttock was healed on the day of audit. All wounds are linked to the care plans. Photos have been taken where relevant. The serviced apartment coordinator/enrolled nurse is the wound champion and has a background in district nursing. She is involved in reviewing non-healing/complex wounds. Ryman wound champions attend zoom meetings with the Ryman wound nurse specialist. The wound champion attended wound care and pressure injury prevention education at Burwood hospital in 2019. Referrals are made as necessary to the dietitian and wound nurse specialist. 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 electronic work log and used to monitor a resident's progress against clinical/care interventions for identified concerns or problems. Monitoring forms reviewed included (but not limited to) blood pressure, weights, blood sugar levels, pain, behaviour, repositioning charts, bowel records, food and fluids, intentional rounding, restraint and neurological observations. Intentional rounding is determined by the residents need including toileting, whereabouts of residents or falls risk.</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 an activity team of three diversional therapists (one in rest home, hospital and dementia care unit). They are supported by activity assistants, lounge carers in the hospital unit and in both dementia units. The caregivers in the dementia unit incorporate activities into their role. The rest home residents in the serviced apartments can choose to attend the rest home or serviced apartment programme. The Engage programme is from Monday to Friday 9.30am - 4.30pm in the rest home and Monday to Sunday in the hospital with a weekend activity assistant. There is an activity assistant two afternoons per week in the hospital to assist with activities and one on one for residents. The hours for the programme in the dementia care unit is from 9.30am to 6pm. Lounge carers are involved in activities. There are plenty of resources available.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including (but not limited to); Triple A exercises, board games,</p>

		<p>news and views, make and create, memory lane, gardening, village walks, small group walks, men's club, movies, indoor bowls, music, happy hour and sensory activities including pet therapy, baking and one on one pampering. Residents enjoy watching or participating in dancing during entertainment and musical events. There are events for the ladies such as high tea and events for the men's group including barbeques and competitions. Townhouse volunteers' partner with residents for dancing. One townhouse resident regularly plays the piano for residents. The village centre hosts integrated activities and events. There are weekly entertainers with happy hour in each unit. Church services are held in the Reflection room and monthly in the dementia care unit.</p> <p>There are weekly van outings and scenic drives for all residents. The van has wheelchair access. Residents are encouraged to maintain community links. Themed events and festive occasions are celebrated.</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. An identity map is completed by the family for all dementia care residents and the information used to develop the individual 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 and surveys. The residents/relatives interviewed were satisfied with the activity programme. Activities were observed in each of the units with good resident attendance and participation.</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>All initial care plans of long-term residents had been evaluated at three weeks prior to the development of the long-term care plan. Six files of residents who had been at the service six months identified that long-term care plans had been evaluated by registered nurses. Four of 10 long-term resident care plans were not due for a six-monthly evaluation (one hospital, one rest home and two dementia care). The respite care resident and end of life resident were not required to have care plans evaluated. Care plans had been updated with any changes to health and care.</p> <p>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. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. The multidisciplinary (MDT) review includes the RN, caregivers, DT, GP, 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 hard copy 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 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. There was evidence of where a resident's condition had changed, the resident was referred for reassessment for a higher level of care from respite to rest home and from rest home to hospital level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, DHB nurse specialists, older persons service, mental health services, nurse Maude and contracted allied professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There 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 are available for all care staff and laundry/housekeeping staff and available 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 provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness. The care centre is across three levels: rest home unit on level 1 (ground floor), hospital unit on the second level and the dementia care unit on the 3rd level. The 40 serviced apartments are across the three levels.</p> <p>The lead maintenance person works full-time and is supported by one part-time maintenance person. The maintenance register is checked daily for repairs and requests and signed off as requests are addressed. There is a monthly planned maintenance schedule which covers internal and external maintenance, resident equipment checks and calibrations, testing and tagging of electrical equipment. Resident hot water temperatures are checked, and records demonstrate the temperatures were below 45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space in the rest home and hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. Two large resident rooms in the rest home unit and the</p>

		<p>hospital unit were assessed as suitable for couples. These were verified as suitable for couples with the following restrictions (limited to two rest home residents or one rest home and one hospital level resident). The ensuites are spacious and safely accessible with the use of a hoist as demonstrated on the day of audit. There is a call bell at the head of each bed space.</p> <p>There is separate gardening and grounds team. Residents are able to access the spacious indoor atrium and outdoor areas safely or with supervision.</p> <p>There is secure entry/exit to the two dementia 20-bed units. Each unit has access to safe balcony courtyard areas with, raised gardens, seating and shade. There is a set of adjoining doors between the units that are open during the day allowing for safe wandering. Residents are regularly taken out to the gardens in the grounds for walks.</p> <p>Care staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All 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>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and</p>	<p>FA</p>	<p>There are 38 single rooms and two double rooms (verified on the day of audit) in the rest home unit and in the hospital unit. All bedrooms across the facility have ensuites. All serviced apartments have a lounge, ensuite and separate bedroom. All bedrooms and ensuites across the rest home/hospital and dementia units 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>

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<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 and rest home units have a large open-plan dining area with kitchenette and open plan lounge area. Seating is arranged to allow large group and small group activities to occur. Both units have a family room and quiet lounge. All serviced apartments also have their own spacious lounge and kitchenette as well as communal dining areas. The village centre is on the ground floor with communal areas available to care centre residents including the hairdresser room, reflection room and library.</p> <p>Each dementia unit has an open-plan living area. Each living area is spacious with a separate dining area. The open plan areas allow for quiet areas and group activities. The hallways and communal areas allow maximum freedom of movement while promoting the safety of residents who are likely to wander. There are alcoves with memorabilia throughout the units. There is free access to the safe outdoor gardens from each unit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance 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 three laundry staff who work staggered starting and finishing times between 6.30am to 10 pm. There are large commercial washing machines, sluice machine, delicate machine and dryers. The clean side has space for folding washing, ironing and a labelling machine. There is minimal unlabelled/unclaimed clothing. There is a large linen storeroom.</p> <p>The service has a secure area for the storage of cleaning trolleys and chemicals. There is a team of cleaners who cover seven days a week, five hours a day. Cleaner's trolleys (sighted) were well equipped. A chemical dispensing unit is used to refill chemical bottles. All chemical bottles have the correct manufacturer's labels. Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Trolleys are stored in locked cleaners' cupboards when not in use.</p> <p>Feedback is received through resident meetings, results of internal audits and surveys. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. Residents and relatives were satisfied with the laundry and cleaning services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Orientation includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The facility has an approved fire evacuation plan and fire drills take place six-monthly. Smoke alarms, sprinkler system and exit signs are in place. Fire warden training last occurred in May 2020. The fire drill was delayed due to covid19, a quality improvement plan was developed, and internal audits and training</p>

<p>appropriate and timely response during emergency and security situations.</p>		<p>was held in place of the drill. The last fire drill occurred in October 2020. An emergency management plan was updated in 2020 to include a folder at each nurse's station and at reception to include essential contact numbers and arm bands. A flip chart of what to do at each stage to including (but not limited to) earthquakes, fire, where the assembly points are and all 'need to know' information. There are five emergency kits which are easily accessible for staff throughout the facility, these include glow sticks, torches, batteries and wrist bands for residents in case of evacuation.</p> <p>Emergency lighting is in place, which runs for at least two hours. The facility has an on-site diesel generator to run essential services. There is a civil defence kit located on each level. Supplies of stored drinkable water is stored in large holding tanks. There is sufficient water stored to ensure three litres per day for three days per resident. There are alternative cooking facilities available with two gas barbeques and gas hobs in the kitchen. Extra blankets are available. First aid boxes are located at reception, both residents' vans, the kitchens and at each nurse's station.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. There are nurse present bells in rooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advised that they conduct security checks inside at night, in addition to an external contractor who checks the external buildings.</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>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. There is underfloor heating throughout the facility. All rooms have electric skope heaters which can be adjusted individually. There are heat pumps in communal areas. There are external windows in resident rooms and communal areas with plenty of natural sunlight. Some internal rooms have doors that open into a large light atrium. Opening doors into the allow for ventilation and the clear atrium roof allows for plenty of natural light</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	<p>FA</p>	<p>The infection prevention and control programme are 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 rest home unit coordinator (registered nurse) is the infection control officer. The infection prevention and control coordinator job description were in place and outlines the role and responsibilities. The infection prevention and control programme are linked into the quality management system. The infection prevention and control committee meet two-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the TeamRyman calendar. Diana Isaac staff have developed links with the GPs, local laboratory, the infection</p>

<p>appropriate to the size and scope of the service.</p>		<p>control and public health departments.</p> <p>There are notices at the entrance reminding visitors not to visit if they are unwell. There is Covid-19 screening in place for all visitors.</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>	<p>FA</p>	<p>The infection prevention and control programme are linked into the quality management system. The infection prevention and control committee meet two-monthly. The facility meetings also include a discussion of infection prevention and control matters. The facility has developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB.</p> <p>Due to current COVID-19 guidelines, all visitors and contractors must complete a wellness declaration and sign into the facility. All visitors and contractors are provided with a mask on entry to the facility. There were adequate supplies of infection control equipment on each floor in the case of outbreaks. A good supply of hand gel, masks and aprons are readily available.</p> <p>A covid19 go kit was implemented in September 2020, and COVID GO drills have been conducted in September 2020 both within working hours and after hours with three separate scenarios. Plans are in place if there were an outbreak around staffing bubbles, changing uniforms, strict controls around housekeeping, laundry and kitchen services. Security has been implemented to screen all visitors and contractors entering the building and ensuring wellness declarations are completed. A fogging machine for deep cleaning residents vacated rooms has been purchased.</p> <p>A COVID-19 preparedness folder has been developed which clearly indicates essential contact numbers of key management, which provides clear easy to follow instructions for staff to follow if covid19 is identified in the facility. A flow chart with instructions of what to do in the first 30 mins, and stages for the first 24 hours. A self-preparedness tool has been implemented and a 'walk through' of the facility is complete at least monthly. The updated pandemic plan and isolation plan is included in the folder.</p> <p>Diana Isaac contracted the district health board, and the infection control team from Christchurch hospital to perform an independent review of processes around outbreak management in August 2020 due to the increase in norovirus outbreaks.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of</p>	<p>FA</p>	<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 19.</p>

<p>infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. Online training was provided around combatting COVID-19, PPE and handwashing was provided as required in March 2020, a session with a microbiologist was also held in March 2020 around Covid19. Infection control education separate to COVID-19 19 is held annually. An education session and debrief was held following the latest norovirus outbreak in September 2020.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator.</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 monthly infection prevention and control (IPC) meetings. All meetings held 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 eight outbreaks at the facility since the last audit in 2018. One gastro outbreak in 2018, influenza A in July 2019, and two norovirus outbreaks in February and October 2019. There was one suspected outbreak recorded in September 2019, but no outbreak was declared on that occasion. There have been three norovirus outbreaks in 2020. All outbreaks have been reported immediately, logs maintained, and procedures followed. Debrief meetings have been held post outbreaks. Training has been held in March 2020 around outbreak management.</p> <p>The service has implemented a quality improvement around the reduction of urinary tract infections, including</p>

		reviewing residents' fluid intake, offering additional fluids throughout the day, with a selection of options available. This has reduced urinary tract infections which remain under benchmark in the rest home and special care units, there has been a recent slight increase in the hospital unit in the period from January to June 2020.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviour. On the days of the audit, there were four residents using restraint, and no residents using an enabler.
Standard 2.2.1: Restraint approval and processes 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.	FA	The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is a clinical manager 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.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. The restraint coordinator in partnership with the GP and approval group, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Three residents' files with restraint use were reviewed. Completed assessments considered those listed in in 2.2.2.1 (a) - (h).

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a clinical manager (registered nurse) and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled 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 three 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 enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<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>	<p>FA</p>	<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 Diana Isaac 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Monthly data collated identified high incidences of challenging behaviour in the dementia care units. A quality improvement project was implemented.	A quality improvement project was implemented. Education sessions were conducted around becoming a dementia friend, and demystifying dementia. A higher level of reporting around challenging behaviour has been implemented to include reasons for challenging behaviours were investigated to rule out possible causes such as infections. The integrated care plan ensures the caregivers have access to resident preferred activities to utilise as a distraction/ diversion technique. Caregivers assist residents with activities along with the lounge carers, which allows for early interventions of distressed behaviour. The dining experience was reviewed in the dementia care units. One dementia care unit provided a more social busier dining area, and the other unit provided a low stimulus dining area. Residents are encouraged to participate in daily exercises and activities of their preference. Staff try to understand the unmet need, identify trends in times or locations, and incorporate this into the care plans. This has resulted in a calm environment and low usage of antipsychotic medications. The GP interviewed commented that care staff were good at re-directing behaviours. The data evidences a reduction from 67.8/1000 bed nights in November 2019 to 29.4/1000 bed nights in September 2020.

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>Residents weight loss is monitored closely by the clinical managers and clinical team. It was identified in 2019 that residents with unintentional weight loss remained around 12%. The service has been successful in reducing unintentional weight loss by 9% over the last 20 months.</p>	<p>Following the resident survey results and the percentage of residents with unintentional weight loss, the service developed a quality initiative around food services including improving the dining experience and increasing resident satisfaction around food services.</p> <p>Online education sessions were held in 2019 and 2020 around dining experience, nutrition, and special diets. The kitchen staff were engaged, and the chef and kitchen assistants were serving meals in the dining rooms. Pure foods were introduced, moulds are used for puree foods, and seating plans were reviewed in the dining rooms. Fluid assistants are involved ensuring residents have adequate food and fluid intake and monitor intake. There were plenty of fluids seen in the unit fridges and the lead chef (interviewed) makes up ensure milkshakes for residents at risk or losing weight. Weight loss interventions have been discussed with the GP and dietitian and interventions are included in the resident's care plans. The chef meets with the dietitian during their visit to discuss dietary requirements and has commented positively on the reduction of unintentional weight loss in residents. The food services lead chef has been included in the management meeting agenda.</p> <p>Staff report residents are staying and chatting to fellow residents at the dining tables after meals, and the rate of unintentional weight loss has decreased, and continues to decrease from 12-14% in 2018, to 12% in January 2019 to 9.8% in January 2020 and to 2.95% in November 2020. Resident satisfaction rates around food were 3.62/5 in 2019 and has increased to 3.96/5 in 2020</p>
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End of the report.