

# Jean Sandel Retirement Village Limited - Jean Sandel Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Jean Sandel Retirement Village Limited
<b>Premises audited:</b>	Jean Sandel Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 3 November 2020      End date: 4 November 2020
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	108



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Jean Sandel is part of the Ryman Group of retirement villages and aged care facilities. The service is certified to provide hospital level care; rest home care and dementia care for up to 112 residents in the care facility and rest home level of care across 20 serviced apartments. On the days of the audit, there were 108 residents, including one resident receiving rest home level of care in serviced apartments.

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

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

This surveillance audit identified improvements required around neurological observations, and the quality programme.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. Residents and family report that communication with management and staff is open and transparent. They also state that they understand how to make a complaint. Complaints and concerns have been managed in a timely manner as per policy and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned and coordinated to meet the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Village goals are documented for the service with evidence of regular reviews since the new village manager has been appointed. Key components of the quality and risk management programme are documented and include management of complaints, an internal audit schedule, completion of satisfaction surveys, analysis of incidents and accidents, and an implemented health and safety programme.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice as per documented policies. A comprehensive orientation programme is in place for new staff. A training plan is documented.

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

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans, and reviews residents' needs, outcomes, and goals with the resident and/or family input. Care plans viewed identified the required interventions and supports to meet the resident individual needs. Care plans are evaluated at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

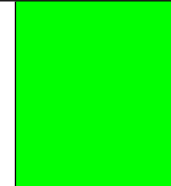
Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the general practitioner.

The activities team implements the activity programme in each unit to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

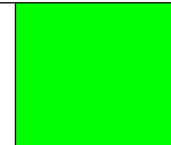


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. There is a reactive and planned maintenance system in place. External areas are safe and well maintained with shade and seating available.

## 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.

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

## 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.

Information obtained through surveillance is tabled and discussed at the infection control meeting and information used to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. One outbreak since the last audit has been well managed. All Ryman Covid-19 precautions have been fully implemented.



## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	39	0	2	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission and in the foyer of the care centre. Residents in the serviced apartments are able to get complaints forms from reception.</p> <p>Interviews with residents and family members confirmed their understanding of the complaints process. Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register is in place. Three complaints were reviewed during the audit. Each was investigated and resolved within timeframes determined by the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is evidence of the complaints being discussed in relevant meetings with appropriate follow-up actions taken. There has been one anonymous complaint from the district health board since the last audit. The manager has responded to the DHB as per their request and the complaint has been signed off by the DHB with no actions required.</p> <p>The following managers and staff were interviewed: one village manager, one assistant manager and the clinical manager; seven caregivers (including caregivers working in the hospital, rest home and dementia units and staff who have worked on mornings, afternoons and night shifts); one enrolled nurse, two registered nurses; the unit coordinators from rest home, serviced apartments, hospital and dementia units; two maintenance and gardening staff; two chefs; two diversional therapists. All were familiar with the complaints</p>

		policy and relevant processes.
<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>Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Fifteen adverse events reviewed included documentation that family had been notified of an incident. Family members interviewed (including two from the hospital and two from the dementia unit) confirmed they are notified following a change of health status of their family member. Residents interviewed (eight from the rest home and two from the hospital) confirmed that there was good communication from the management team, unit coordinators and registered nurses (RNs).</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p> <p>There has been extensive communication to residents and relatives around Covid 19. This included provision of information around infection control practices put in place.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Jean Sandel Retirement Village is located in New Plymouth. The facility is modern and spacious and extends across a flat section with the ground floor (rest home level of care, reception, village activities centres, atrium, offices etc) and level one which is referred to as the hospital wing and includes a secure dementia unit. Both levels include service apartments.</p> <p>There are 112 beds in the care centre along with an additional 20 serviced apartments certified for residents assessed at rest home level of care. One lounge on level one is certified as being able to accommodate any DHB referral for emergency respite care.</p> <p>On the day of audit, there were a total of 108 residents. There were 46 residents requiring rest home level of care (including eight on level one and one in a serviced apartment); 22 residents in the dementia unit (full occupancy); 40 residents requiring hospital level of care. One resident in the hospital wing was under a respite contract and one resident in the hospital was identified as a young person with a disability and under a YPD contract. All remaining residents were on the age-related residential care (ARC) contract.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually, specific to Jean Sandel Retirement Village. Each objective includes an action place and person(s) responsible. There are specific projects with action plans related to clinical, health and safety, and resident/relative feedback. The previous plan was reviewed by the newly appointed village manager with details of progress now reported quarterly.</p> <p>The village manager at Jean Sandel Retirement Village has been in the role for six months with a background in hospitality management. They are supported by the regional manager. The village manager is supported by</p>

		<p>an assistant manager who has been in the role for nine years with a background in administration and a clinical manager who has been in the role for four years. The clinical manager has a master's management (health and social care) and has a background in working with vulnerable people. The managers are supported by a unit coordinator (UC) in each area. All unit coordinators are registered nurses apart from one who is an enrolled nurse.</p> <p>The managers have maintained more than eight hours annually of professional development related to managing an aged care service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management system that is directed by head office (Ryman Christchurch) is established and implemented. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with managers and staff, and the review of meeting minutes demonstrated the collective involvement of managers and staff in quality and risk management activities.</p> <p>Resident meetings are held bi-monthly for each service level and relative meetings are scheduled six-monthly. The village manager attends the meetings, and minutes are maintained. Resident and relative surveys are completed annually.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, as evidenced in meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting.</p> <p>The facility has documented processes to collect, analyse and evaluate data. Improvement plans are documented when issues are identified from relative and resident surveys and from internal audit reports. An incident and infection analysis report is tabled at each meeting, however there is a lack of documentation of discussion of issues in full staff meetings or clinical meetings. Where issues are identified in the infection control committee, there is a lack of follow through to the clinical RN/enrolled nurse to show that actions have been resolved.</p> <p>Results of surveys are communicated to staff across a variety of meetings including full facility meetings, clinical meetings, restraint, caregiver, health and safety, infection control, activities, and infection control meetings. The internal audit programme is followed as per the schedule.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. A health and</p>

		<p>safety officer was interviewed, and they were able to describe their role as per the job description. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. Health and safety data is tabled at staff and management meetings. A review of the risk register and the maintenance register indicated that there is resolution of issues identified. All new staff and contractors are inducted to health and safety processes. There is also annual in-service training and competency assessments.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls with a range of examples provided (e.g. providing falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; routine checks of all residents specific to each resident's needs (intentional rounding); the use of sensor mats and night lights; and increased staff awareness of residents who are at risk of falling. Care staff interviewed were knowledgeable in regard to preventing falls and identifying those residents who were at risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise, and debriefing. Individual incident reports are completed electronically using VCare for each incident/accident with immediate action(s) and any follow-up action required evidenced.</p> <p>A review of 15 incident/accident reports (including witnessed and unwitnessed falls, pressure injury, challenging behaviours) included follow-up by a registered nurse. Consistent evidence of timely neurological observations were not always documented if there was a suspected injury to the head or an unwitnessed fall (link 1.3.6.1).</p> <p>The managers and unit coordinators are involved in the adverse event process via regular management meetings and informal meetings during the week that provide an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations would be reported to statutory authorities, (e.g. Section 31 reports were sighted for pressure injuries and for the appointment of the village manager six months prior to the audit).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	<p>FA</p>	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation, and staff training and development. Eight staff files were selected for review (clinical manager, two-unit coordinators, two registered nurses, one enrolled nurse, one lifestyle coordinator, one caregiver). Each file included an application form and two reference checks, a signed employment contract, job description, police check, and</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>completed orientation programme. The majority of staff files reviewed included a current annual performance appraisal with two still due this year.</p> <p>Practicing certificates for health practitioners including the registered nurses, (doctors and nurse practitioner, physiotherapists, dietitian, pharmacists) are retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. The general orientation programme that is attended by all staff includes Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an annual education plan. Staff training records are maintained electronically. Of the 16 registered nurses (including unit coordinators), five have completed interRAI training. Registered nurses also complete journal club bimonthly. A minimum of one staff holding a current CPR/first aid certificate is rostered onto each shift and they are available on outings. Rosters reviewed confirmed that there was a caregiver or registered nurse with a first aid certificate on each shift.</p> <p>The following numbers of staff have completed certificates: two have certificates in health and wellbeing level two with three who have completed foundation level two; five who have completed level three; 20 who have completed level four; 30 who have completed level three dementia unit standards; eight in the process of completing dementia unit standards; two who have a diploma in health service level seven; and two diversional therapists level four. All healthcare assistants who work in the dementia unit have completed the required dementia standards. There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, assistant manager, and clinical manager work Tuesday – Saturday.</p> <p>Four-unit coordinators (one hospital/RN, one rest home/RN, one dementia/RN, one serviced apartments/EN) work full time. The appointment of the hospital unit coordinator has led to an improvement in satisfaction of residents in that area.</p> <p>The ground floor (rest home residents) is staffed with a unit coordinator (Tuesday to Saturday), one registered nurse five days a week working from 8AM to 12PM, and four caregivers (two long shift and two from 7AM to 1PM). There are two caregivers on a long shift (including one senior) and one short shift in the afternoon and</p>

		<p>two caregivers overnight.</p> <p>Level one (occupancy eight rest home residents and 40 hospital residents) is staffed with a unit coordinator on the AM shift along with seven caregivers (three long shifts and four short shift) and two RNs; seven caregivers in the afternoon (including four short shift) and two RNs; three caregivers and one registered nurse overnight.</p> <p>The dementia unit is staffed on the morning shift with three caregivers (including one short shift), the same in the afternoon and two caregivers overnight. A full-time unit coordinator provides registered nurse oversight and support. All caregivers in the dementia unit have completed dementia level training.</p> <p>Serviced apartments (one rest home level resident) is staffed with one-unit coordinator/EN five days a week and a senior caregiver the remaining days. Staff from level one respond to any calls in the serviced apartments overnight. The call system is linked to their pagers. If there are callouts from the village units, they are attended by a caregiver from the rest home ground floor wing with a phone call first to ensure that the person is not able to answer.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurses and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (rest home, hospital, serviced apartments, and dementia care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. The RN signs the back of the blister pack when checked. An impress supply order is maintained for hospital level residents. Impress levels and expiry dates are checked regularly. All medications were within the expiry dates. Eyedrops in all units were dated on opening.</p> <p>The medication fridge temperatures are checked weekly in the rest home and dementia care unit and daily in the hospital unit. Medication room air temperatures are checked and recorded daily.</p> <p>There were two hospital and two rest home residents self-medicating on the day of audit. Self-medication competencies had been completed and reviewed three-monthly by the RN and authorised by the GP.</p> <p>Fourteen medication charts on the electronic medication system were reviewed (six hospital, four rest home and four dementia care). Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded on each chart. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the</p>

		electronic medication system.
<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>	FA	<p>The lead chef is supported by a second chef, cooks assistants, morning, and afternoon kitchenhands. All food services staff have completed food safety and hygiene training. Project 'delicious' has been implemented and the menus reviewed by a dietitian at organisational level. The four-week rotating seasonal menu offers a variety of choices, including a vegetarian and gluten free option. Pureed/soft meals are provided. Special diets are plated and labelled. Meals are delivered in hot boxes and served from bain maries in each unit. A sample plated meal is delivered to each unit for serving staff to follow for consistency in presentation.</p> <p>Special equipment such as lipped plates are available. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen. There are nutritious snacks available at all times in the dementia unit. Fruit bowls are available in all units.</p> <p>The food control plan expires 9 May 2021. Chiller, freezer, end cooked and serving temperatures are taken and recorded twice daily. Incoming chilled goods have temperatures recorded on delivery. Calibration of temperature probes are done three-monthly. A cleaning schedule is maintained. Chemicals are stored safely.</p> <p>Residents and family members interviewed were satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition changes, the registered nurse initiates a GP, nurse practitioner (NP) or nurse specialist consultation. Registered nurses interviewed, stated that they notify family members about any changes in their relative's health status. Family members interviewed, confirmed they are notified of any changes to health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. The myRyman care plans are updated when there are changes to health, risk, infections or monitoring requirements.</p> <p>Care staff interviewed, stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are documented electronically, and wound monitoring occurs as planned in the sample of wounds reviewed (11 hospital, two rest home and two dementia care). There were five pressure injuries (one stage 1 and four stage 2) of hospital residents (facility acquired). One resident had three stage 2 pressure injuries of toes from shoes. The rest home unit coordinator is the wound care champion and has attended wound care training. There is access to the DHB wound care nurse specialist if required. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position and pressure area cares electronically.</p>



		<p>Electronic monitoring forms are in use as applicable, such as weight, food and fluid, vital signs, blood sugar levels, pain, bowel monitoring, neurological observations, wound monitoring, and behaviour charts. The RNs review the monitoring charts daily. There is a shortfall around completion of neurological observations.</p>
<p><b>Standard 1.3.7: 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>FA</p>	<p>A team of activity and lifestyle coordinators include three qualified diversional therapists (DT). The DTs are supported by lounge carers and activity assistants to implement the Engage activities programme. The programme reflects the physical and cognitive abilities of the resident groups. The hospital and dementia programme is Monday to Sunday and in the rest home Monday to Friday. Volunteers from the townhouse assist with activities and one on one time with residents. There are plenty of resources available in each unit. The rest home resident in a serviced apartment can choose to attend the serviced apartment or rest home activity programme.</p> <p>The weekly programme for each unit is displayed on noticeboards and residents have a copy in their rooms. The programmes include set Engage activities in which residents can choose to participate, including (but not limited to); triple A exercises, board games, mind benders, quizzes, music, reminiscing, sensory activities, crafts and walks outside. Staff, resident's family and townhouse residents visits with their dogs. There are some combined activities including church services, events, and festivities. The men's club involve men from all levels of care. Happy hour with an entertainer is held in each unit.</p> <p>One-on-one time is spent with residents who prefer to stay in their room or are unable to actively participate in group activities. The programme in the dementia care unit is flexible to meet the residents needs and abilities. Caregivers include activities as part of their role. Both auditors observed activities happening at various times during the day for residents in the dementia unit. Activities were also observed in the rest home and the hospital.</p> <p>The service hires a mobility van for hospital resident outings and there are vans for rest home and dementia care resident outings. The van driver has a first aid certificate. Residents attend events in the community and maintain links with community groups such as stroke and enjoy inter-home functions. The programme was disrupted during Covid-19 lockdown, however all residents and relatives interviewed stated the activity team continued to provide a variety of activities on-site and there were phone calls, zoom meetings, cards, and photos for family.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed were satisfied with the activities offered.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six long-term resident care plans reviewed had a documented evaluation completed by the registered nurses after three weeks and six monthly thereafter, or when changes to care occurs. One resident was respite care and did not require an evaluation of care. The multidisciplinary review involves the RN, CG, lifestyle coordinator and resident/family are invited to attend. Activities plans are evaluated at the same time as the care plan. There are three monthly reviews by the GP, or earlier for residents with more complex needs. Family members interviewed confirmed that they are informed of any changes to the care plan.</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 holds a current warrant of fitness which expires 24 January 2021. There are three full-time maintenance persons who cover the village. There is a separate gardening team. A maintenance register at the main reception is available for staff/residents to record maintenance/repairs required. There is a planned maintenance schedule that had been completed on a monthly basis and includes environmental, residential equipment checks, compliance fire checks, testing and tagging and monitoring of resident hot water temperatures. Tempering valves have been replaced within the last six months to correct temperatures above 45 degrees Celsius. There are preferred contractors who were involved in the build and knowledgeable about the site and services.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, gardens and courtyards are well maintained and safely accessible. All outdoor areas have seating and shade.</p> <p>The dementia unit is on the second floor with an outdoor safe deck area with raised garden beds. An indoor/outdoor walking pathway is accessible for residents.</p> <p>Caregivers interviewed, stated they have adequate equipment to safely deliver care for rest home, hospital, and dementia level of care residents.</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 policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection prevention coordinators complete a monthly report. Monthly data is reported to the infection control committee and meeting minutes are available to staff. Staff are informed of surveillance through the variety of clinical meetings held at the facility.</p> <p>The infection prevention and control programme links with the quality programme including internal audits.</p> <p>There is close liaison with the GPs and laboratory service that advise and provide feedback and information to</p>

		<p>the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking against other Ryman facilities occur.</p> <p>Quality improvements are commenced for any areas identified for improvement an example includes additional training for staff around wound care following a spike in wound infections in the dementia unit. One gastroenteritis outbreak was well managed during August 2019. Public health was informed, and staff followed policies around outbreaks.</p> <p>Ryman Jean Sandel has implemented the Ryman Covid-19 precautions. All visitors wear masks, have temperatures recorded and must complete health screening. An additional cleaning schedule has been implemented. Weekly updates from the central office have been sent to all Ryman facilities including Jean Sandel.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>The clinical manager is the restraint coordinator. On interview they confirmed knowledge around both restraints and enablers. During the audit, there were no residents using any restraints or enablers.</p> <p>Staff training including staff competencies are implemented addressing restraint minimisation and enablers, falls prevention and analysis, and the management of challenging behaviours. This begins during their induction to the service and continues annually.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Quality improvement plans are documented when there are issues identified in the relative and resident surveys. There is evidence of documentation of improvement plans with improvements reported and resolution of issues documented.</p> <p>An incident and infection analysis report is tabled at each meeting, however there is a lack of documentation of discussion of issues at clinical and staff meetings. Staff and managers state that there is discussion around issues and concerns related to the report.</p> <p>When issues are identified e.g. in the infection control committee, there is a lack of follow through to the clinical meeting minutes to show that actions have been discussed and resolved.</p>	<p>(i). Meeting minutes do not always show discussion of data and implementation of actions as per improvement plans. (ii). Evidence of resolution of issues is not always documented.</p>	<p>(i). Document evidence of discussion of data and implementation of improvement plans. (ii). Document evidence of resolution of issues.</p> <p>180 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Monitoring forms and the frequency of monitoring are scheduled on the caregiver or RN schedule. When a resident has an unwitnessed fall the falls protocol is implemented which includes neurological observations.</p>	<p>Six of 15 unwitnessed falls did not have the neurological observations completed as per protocol.</p>	<p>Ensure neurological observations are completed as per protocol for unwitnessed falls.</p> <p>90 days</p>

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

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

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

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

No data to display
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End of the report.