

Frances Hodgkins Retirement Village Limited - Frances Hodgkins 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: Frances Hodgkins Retirement Village Limited

Premises audited: Frances Hodgkins Retirement Village

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 22 March 2021 End date: 23 March 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 49



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 |
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|  | 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 |
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| | 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

Frances Hodgkins is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home care level care for up to 51 residents in the care centre and rest home level of care for up to 32 residents in serviced apartments. On the day of audit there were 49 residents in the care centre and no rest home level residents in serviced apartments.

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

The service is managed by a village manager (registered nurse) who has been in the role 13 years. She is supported by a clinical manager who has been in the role 15 years. The residents and relatives interviewed spoke positively about the care and support provided.

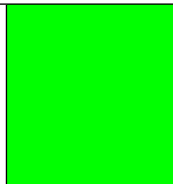
There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Ryman quality and risk management programme. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

MyRyman electronic care plans and monitoring systems were individualised and comprehensively completed for all resident reviewed. 'At risk' residents were identified, and monitoring strategies were implemented and regularly evaluated.

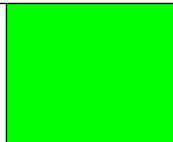
The service has been awarded a continuous improvement rating around implementation of the quality programme.

Consumer rights

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| 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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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

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| 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. |
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Services are planned, coordinated, and appropriate to the needs of the residents. The village manager, and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A

comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training are in place, which includes in-service education and competency assessments. The resident and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

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| 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 package for residents/relatives on admission to the service. InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses within the required timeframes. The electronic care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans reviewed have been updated for changes in health status.

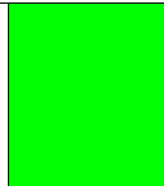
The activities staff provide an activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the group of residents.

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

The menu is designed by a dietitian at an organisational level and meets the resident preferences. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food that is provided.

Safe and appropriate environment

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

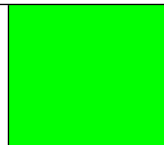


Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with a mix of toilet and hand basin ensuites and full ensuites. There are adequate numbers of communal shower rooms. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service has no residents using enablers or restraint.

Infection prevention and control

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| <p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p> | | <p>Standards applicable to this service fully attained.</p> |
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The infection prevention and control programme include policies and procedures to guide staff. The infection prevention and control team hold integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. Covid-19 screening was well managed, and documentation is held on record. Contact tracing remains in place. Adequate supplies of personal protective equipment were sighted throughout the facility.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| Standards | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 92 | 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 |
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| <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, clinical manager, regional operations manager, and staff (six caregivers, two registered nurses (RNs), activity coordinator, two housekeeping staff, and one kitchen staff) confirmed their familiarity with the Code. The Code is discussed at all meetings including resident and relative 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 make informed choices and give informed consent.</p> | FA | <p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. Seven rest home resident files reviewed (including one respite resident) included written consents. General consents included the consent for photographs and sharing of medical information. Specific consent was obtained such as influenza vaccines. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care.</p> <p>A resuscitation status was signed by the competent residents and witnessed by the general practitioner (GP). Where the resident was unable to make a decision, the GP makes a medically indicated not for resuscitation in consultation with the enduring power of attorney (EPOA). Copies of EPOA and activation status where appropriate was available on the resident file. Copies of advance directives were available</p> |

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| | | <p>where these had been completed.</p> <p>Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Admission agreements for six long-term resident files under the ARCC had been signed within a timely manner. There was a short-term admission agreement in place for the respite care resident.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>Residents are provided with a copy of the Code on entry to the service. The resident files included information on residents' family/whānau and chosen social networks. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. Residents interviewed confirmed they are aware of their right to access independent advocacy services.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>The activities programmes include opportunities to attend events outside of the facility including activities of daily living, such as shopping. There is a hairdresser available. The facility has links with several groups in the community which residents attend. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>The village manager investigates complaints in consultation with the clinical manager. Escalation of complaints to the regional operations manager is dependent on the severity of the complaint. A complaint register (in hard copy and on the electronic system) is maintained for all written and verbal complaints with dates acknowledged, actions taken, investigation and letters of outcomes or face-to-face meetings with the complainants. Complaints are being managed in a timely manner and within timeframes determined by the Health and Disability Commissioner (HDC).</p> <p>Since the previous audit, there have been a total of four complaints lodged, one written complaint in 2019, and two written and one verbal in 2020. There have been no complaints (to date) in 2021. There is evidence of complaints received being discussed in management meetings and staff meetings. All</p> |

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| | | complaints received were investigated to the satisfaction of the complainant. |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | FA | <p>An admission information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. The village manager or the clinical manager discusses the information pack with residents/relatives on admission. Large print posters of the Code and advocacy information are displayed on noticeboards throughout the facility. An education session around rights, responsibilities and advocacy services was held during a full facility meeting in November 2019 (43 attended) and 32 staff completed the Rights and responsibility self-directed learning package.</p> <p>Interviews with eight residents and two relatives confirmed that the services being provided are in line with the Code, and that information around the Code had been provided to them. Residents and relatives interviewed confirmed there was the opportunity to discuss aspects of the Code during the admission process.</p> <p>Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code.</p> <p>During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. A tour of the premises confirmed there were areas that support personal privacy for residents. Communal showers have locks, engaged signs and curtains. The interviewed caregivers showed a good understanding of the different types of abuse and neglect and signs and symptoms residents may present. Caregivers interviewed described how they gave residents choice. The individual tablets in resident rooms also reinforced resident's normal routine and choices. Staff have undertaken annual training on abuse and neglect during June 2019 with 41 attending. Vulnerability in-service was held March 2020 with 23 attending.</p> <p>Residents and relatives' members interviewed confirmed that staff promote the residents' independence wherever possible, and that residents' choices are encouraged.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as</p> | FA | <p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has a link with the SDHB for Maori advice and</p> |

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| <p>Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | | <p>guidance as needed.</p> <p>Cultural considerations including Māori language week are discussed in TeamRyman meetings. There were no residents at the facility on the day of audit that identified as Maori.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Frances Hodgkins has established cultural policies aimed at helping to meet the cultural needs of its residents.</p> <p>The residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All residents at the facility were able to speak and understand English. A cultural awareness and safety training session was provided to staff in September 2019 (40 attended) 2020.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>Staff job descriptions include responsibilities. Full TeamRyman meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Unconscious Bias training was provided to staff February 2020 (23 attended).</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <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. Ongoing quality improvement initiatives are implemented. Monthly benchmarking reports occur for all incidents against other Ryman care centres. The clinical manager completes an analysis report and corrective actions implemented where required i.e.: pressure injuries.</p> <p>Registered nursing staff are available over seven morning shifts a week and the clinical manager is on call. The service receives support from the district health board which includes visits from specialists (e.g., wound care, mental health) and staff education and training. 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. Quality improvement initiatives implemented in 2020 at</p> |

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| | | <p>Frances Hodgkins have included (but not limited to) falls prevention and respiratory tract infections. Since the last audit the service has made improvements to outdoor areas and landscaped walking, garden areas and extended the deck overlooking the city. They have also refurbished dining room, reception/offices, refurbished and extended kitchen. They have introduced physiotherapy to residents who fall frequently, and they have gradually been replacing divan beds to electric beds.</p> |
| <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 are required to record family notification when entering an incident into the system. Eleven incidents reviewed met this requirement. Relatives interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. Residents and relatives were particularly complimentary when discussing communication during the Covid19 lockdown. Resident and relative meetings include a forum to discuss issues and provide feedback and quality data/survey outcomes etc. The 2020 relative survey identified Francis Hodgkins were ranked 3rd overall across all Ryman villages around communication with relatives.</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>Frances Hodgkins is a Ryman healthcare retirement village. They are certified to provide rest home level care for up to 51 residents in the care centre and rest home level care for up to 32 residents in the adjoining serviced apartment building. There are 49 residents in the care centre including two respite residents and one resident assessed as hospital level care last week (awaiting transfer to another facility). There were no rest home residents in the apartments.</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values and beliefs are documented that are specific to Ryman Frances Hodgkins. The village objectives are reviewed quarterly, and progress reported to head office. The service has met three of four of their 2020 quality objectives. Objectives met include: (i) reducing the incidence of pressure injuries; (ii) minimising falls (below 11 per 100 bed nights); (iii) Educate all staff on working with and managing residents with dementia. There are weekly management meetings. The village manager reports to the regional operations manager who was present on day one of the audit.</p> <p>The service is managed by a village manager (registered nurse) who has been in the role 13 years. She is supported by a clinical manager who has been in the role 15 years. The management team is supported by stable and long-serving staff.</p> <p>The village manager and clinical manager have attended in excess of eight hours education including Ryman village manager training days.</p> |

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| <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> | FA | <p>During the temporary absence of the village manager, the clinical manager would provide this role with support from the Ryman Christchurch team.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>Frances Hodgkins has a well-established quality and risk management system that is directed by Ryman Christchurch (head office). Quality and risk performance are reported at the weekly management meetings and also to the organisation's management team. Quality data, quality initiatives and corrective action plans are discussed at the monthly full facility meetings, clinical meetings and other facility meetings held across the site. Meeting minutes are made available to staff. Discussions with the managers and staff and review of management and staff meeting minutes, demonstrated their involvement in quality and risk management activities. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. There is an internal auditing programme set out by head office. The service develops a corrective action plan for any audit result below 90%. A quality improvement register is maintained. Corrective actions are signed off when completed and audit results are communicated at the management and facility meetings.</p> <p>The facility has implemented processes to collect, analyse and evaluate data including resident and staff accident/incidents, hazards, infections, complaints and audit outcomes, which is utilised for service improvements. Quality improvement plans have been developed for areas identified for improvement including (but not limited to); increasing resident satisfaction with activities programme, reduction in respiratory tract infections and falls reductions. Action plans have been implemented and demonstrated ongoing improvements in these areas. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed.</p> <p>Resident and relative surveys are completed annually. Care centre relative survey results for 2020 identified the service ranked 5th across all Ryman facilities for satisfaction. The average score was 4.41 out of 5. The rest home resident survey 2020 results ranked the service as 21st across Ryman facilities. Corrective actions were implemented Survey results and consequent actions were communicated to</p> |

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| | | <p>residents, relatives and staff through meetings.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in staff meeting minutes and staff interviews.</p> <p>Health and safety policies are implemented and monitored by the monthly health and safety committee who are representative of the facility. The health and safety representative is a senior caregiver and has been in the role for eight years. There is a strong focus on identifying and reporting hazards. The risk register is regularly reviewed. Ryman have initiated "step back" cards that are completed following every incident to analysis and identify the root cause. The noticeboard keeps staff informed on health and safety meetings. Head office sends out health and safety bulletins regularly and alerts for staff information and awareness. There are regular manual handling sessions taken by the physiotherapist.</p> <p>During the Covid19 period, the management reviewed options for an improved means of communication with staff so implemented the social media "Chattr" channel.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contracts a physiotherapist weekly. Care staff interviewed could describe falls prevention strategies as documented in myRyman care plans.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded 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 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.</p> <p>Staff report all incidents and accidents to the clinical manager who then enter details into the electronic system. Incidents are linked via the myRyman electronic system where post incident assessments are completed which link to the VCare incident data gathering.</p> <p>A review of eleven electronic incident/accident forms (Feb/March) 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>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>The village manager and clinical manager were able to identify significant events that would be reported</p> |

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| | | to statutory authorities. There has been none required to be reported since the last audit. |
| <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. Nine staff files reviewed; (two registered nurse, three caregivers, one activities coordinator, one housekeeper, one chef, and one maintenance person.) included a signed contract, job description, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals. A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. New staff complete full induction with 'all employees induction modules within the first week, then move to complete orientation and Ryman specific role induction modules.</p> <p>A register of registered nurse's practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>There is an implemented annual education plan. Each month the service is informed, via TeamRyman regarding what education is to be provided as well as any resources needed. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. There are three registered nurses (RNs) and two RNs including the clinical manager have completed the interRAI training. Staff have completed the core competencies relevant to their role. A number e-learning courses and competencies are completed by myRyman, moving & handling, wound assessment, insulin administration & BGL monitoring and medication administration.</p> <p>Caregivers are encouraged to gain qualifications with the New Zealand Qualification Authority (NZQA). There are a total of 34 caregivers, 11 have level four, eight have level three and eight have level two.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The service staffing includes.</p> <p>A village manager (RN) who works Monday to Friday, and the clinical manager who works Tuesday to Saturday. The clinical manager, and village manager are in addition to the rostered staffing. A registered nurse works Monday and Sunday 7.30 am to 4pm. There is a further registered nurse from 8am to 1.30pm across seven days a week.</p> <p>The morning shift has five caregivers; 1x 7am to 3.30 pm, 1x 7am to 3 pm, 2x 7am to 1.30 pm, and 1x 7.00 am to 12.30 pm.</p> |

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| | | <p>The activity and lifestyle coordinator works Mon- Fri 9.30 am – 4.30 pm.</p> <p>The afternoon shift has four caregivers: 2x 3 pm to 11pm, and 2x 4 pm to 9.00 pm.</p> <p>There are two caregivers on night shift 10.45 pm – 7.17 am and 11 pm to 7 am.</p> <p>There is a cover pool available each day.</p> <p>Serviced Apartments – There is a specific roster for the apartment block.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>The resident electronic files reviewed were appropriate to the service type. Residents entering the service have all relevant initial information recorded into the resident's individual record within 24 hours of entry. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Electronic resident files were protected from unauthorised access. Entries were dated and included relevant caregiver or registered nurse, including designation. The electronic system (myRyman) demonstrated service integration of resident records.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service provides an information pack available for potential residents/families/whanau. The admission agreement reviewed aligns with the services contracts for long-term care.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file including Covid-19 screening tools. All relevant information is documented and communicated to the receiving health provider or service including advance directives or medical care guidance documentation. Transfer notes and discharge information was available in the hard copy resident records of those with previous hospital admissions. The myRyman programme generates transfer notes for any transfers. A resident was transferred to hospital on the day of audit and the paramedic stated the transfer information is excellent and very helpful.</p> |
| <p>Standard 1.3.12: Medicine</p> | FA | <p>There are policies and procedures in place for safe medicine management that meet legislative</p> |

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| <p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>requirements. All medications for the rest home residents are stored safely in the rest home medication room. Registered nurses and senior caregiver's complete annual medication competencies and attend medication education. Medication reconciliation of monthly blister packs and as required blister packs is checked by an RN and documented on a reconciliation checklist. Any errors are fed back to the pharmacy. There were three rest home residents who were self-medicating with a self-medicating assessment in place which had been reviewed three-monthly by the GP. The medication fridge temperatures are taken weekly and within the acceptable range. Medication room air temperatures are taken and recorded daily. All eye drops in medication trolley had been dated on opening. There are no standing orders.</p> <p>The service uses an electronic medication system. Fourteen medication charts were reviewed (13 electronic and one paper-based). All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that regular medications were administered as prescribed. As required medications had the indication for use documented. The effectiveness of as required medications has been recorded in the electronic medication system and in the progress notes.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>All food and baking are prepared and cooked on-site. The kitchen is adjacent to the large rest home dining room. Food is hot boxed to the serviced apartments at mealtimes. The head chef works five days a week and is supported by a weekend chef, morning and afternoon kitchenhands. All food services staff have completed food safety training. The seasonal menu provides one main option and vegetarian option. There are alternative foods offered for known dislikes. The organisational dietitian has reviewed the menu. Special diets include pureed meals for those with swallowing difficulties. Pure foods are used for pureed meals and as a base for other soups and foods. The service has focused on improving the dining experience offering preferred meals and refurbishing the dining room.</p> <p>The service has a current food control plan. End cooked temperatures, fridges, freezer, cooking and cooling and incoming goods have temperatures checked and recorded. All foods were stored correctly, and date labelled. A cleaning schedule is maintained. The chemical provider completes dishwasher temperature and chemical efficiency checks monthly. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings and direct contact with the food services staff. Resident and relatives interviewed spoke positively about the meals provided.</p> |
| <p>Standard 1.3.2: Declining</p> | FA | <p>The service records the reason for declining service entry to potential residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs</p> |

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| <p>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>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 all the files reviewed, an initial assessment (part 1 and 2) and relevant risk assessment tools had been completed on admission. The outcomes of interRAI assessments for long-term residents and risk assessments were reflected in the electronic care plans reviewed. Additional assessments such as (but not limited to) behavioural, falls, nutritional, pressure injury, pain, wound and physiotherapy assessments were completed according to need. There are a number of assessments completed that assess resident needs holistically such as cultural and spiritual and activities assessments. The assessments generate interventions and supports completed by the RNs that are transferred to the myRyman care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p> |
| <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 electronic care plans for all resident files (including the respite care) outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met. The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall, likes and dislikes. Residents/relatives sign a care plan acknowledgement form that evidences resident/family/whānau involvement in the care planning process. Relatives interviewed confirmed they were involved in the development and review of care plans. Care plans included involvement of allied health professionals in the care of the resident such as the GP, physio, geriatrician, dietitian, wound nurse, older persons health service and community gerontology nurse.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate</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 and their expectations of the service were being met. When a resident's condition changes, the registered nurse initiates a review and if required a GP or nurse specialist consultation. The care plans are updated with any changes to care and required health</p> |

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| <p>and appropriate services in order to meet their assessed needs and desired outcomes.</p> | | <p>monitoring interventions for individual residents are scheduled on the RN or caregiver work log.</p> <p>Wound assessments, treatment and evaluations were in place for six wounds. There were no pressure injuries on the day of audit. The RN wound care champion/clinical manager has attended wound care training. Wound assessments include the size of the wound, photographs and consider presence of pain. All wounds are linked to the long-term care plan. The service has pressure relieving resources available if required.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring requirements are scheduled on the work log and used to monitor a resident's progress against clinical/care interventions for identified concerns or problems. Monitoring forms reviewed on the electronic work logs included blood pressure, weights, blood sugar levels, pain, behaviour, bowel records, food and fluids, intentional rounding and neurological observations. Intentional rounding is determined by the residents need including toileting or falls risk.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The service employs a diversional therapist (DT) to implement the Engage programme for the rest home residents and another activities coordinator for the serviced apartment residents. Both staff work 32 hours per week. Another staff member is employed for van outings and to cover for staff leave. There are resources available in the weekends for residents, families and care staff to access. The rest home residents in serviced apartments can choose to attend activities in the rest home or serviced apartments.</p> <p>The Engage programme has been implemented. There are set activities with the flexibility to add activities that are meaningful and relevant for the resident group including (but not limited to); Triple A exercises, mind benders, board games, news and views, memory lane, crafts, gardening, walks, happy hour, hand massage and aromatherapy, sing-a-longs and indoor bowls. There are a number of clubs such as men's club, book club, painting club, knit and knatter and card club. Church services are combined for all residents. There is weekly entertainment and twice weekly outings/scenic drives.</p> <p>Themed events and festive occasions are celebrated. Residents are invited to attend community events.</p> <p>Activities continued during the Covid-19 lockdown period whilst maintaining social distancing. Hallway activities such as exercises, housie and sing-a-longs occurred. One on one crafts and other activities were provided in resident rooms. There were zoom meetings with families on the resident room devices.</p> <p>Resident life experiences and an activity assessment is completed for residents on admission. The resident/family/whānau (as appropriate) are involved in the development of the activity plan which is</p> |

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| | | incorporated into the myRyman care plan. The activity plan is evaluated six-monthly with the MDT review. Residents/relatives can feedback on the programme through the two monthly resident meetings and annual surveys. The residents and relatives interviewed stated they were very happy with the activities offered. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Six long-term files identified that the initial assessment had been evaluated within 21 days, in consultation with the resident/relative prior to the development of the long-term care plan. Long-term care plans had been evaluated six-monthly for long-term residents who had been at the service six months. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. Written evaluations describe the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. The multidisciplinary (MDT) review includes input from the RN, caregivers, DT, GP, resident, relative and any other health professionals involved in the resident's care. A record the MDT review is kept in the resident hard copy file. The family are invited to attend the MDT review and are notified of any changes if unable to attend. Care plans had been updated with any changes to health and care. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, and contracted allied professionals. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or | FA | There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets and product use information was readily available. The chemical provider monitors the effectiveness of chemicals. Relevant staff have completed chemical safety. |

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| hazardous substances, generated during service delivery. | | |
| <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 an extended building warrant of fitness. The warrant of fitness was due in December 2020 but due to COVID-19 lockdown and restrictions, has been extended by the local district council for a further year (letter sighted). The facility employs a full-time maintenance person. The maintenance person ensures daily maintenance requests recorded in the register are addressed. The full-time gardener also assists with maintenance requests. There are preferred contractors available for essential services. A planned maintenance schedule has been maintained and includes electrical testing and tagging, calibration and functional checks of medical equipment, call bells checks and resident hot water temperature monitoring. Temperature recordings reviewed were below 45 degrees Celsius.</p> <p>Environmental improvements include internal refurbishments of the dining room, laundry, staff room, reception and offices. Externally the service has completed landscaping of the outdoor areas, and a new extended deck area. The facility corridors provide sufficient space for residents to safely mobilise using mobility aids. Seating and shade are provided in the outside areas.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. Most rest home beds have been replaced with electric high-low beds as part of the bed replacement plan.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>All rest home bedrooms are single occupancy and have toilet and basin ensembles. There were communal toilets located closely to the communal areas. Toilets have privacy locks. There are adequate communal showers available with privacy locks and privacy curtains in place. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p> | FA | <p>All residents' rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p> |

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| areas appropriate to the consumer group and setting. | | |
| <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 facility has a large communal dining room for rest home residents. The large main lounges have seating placed to allow for individual or group activities, with access from both lounges to the external courtyards and decks. There are areas available for quieter activities such as reading and for visitors.</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 of the cleaning and laundry service. All linen and personal clothing is laundered on-site. There are designated laundry and housekeeping staff. The laundry operates from 10am to 4pm seven days a week. There is two door entrance and exit system for clean/dirty flow. There is a sluice tub located in each wing with available personal protective equipment. Laundry equipment is serviced regularly.</p> <p>There are two cleaners on daily for the rest home. There is additional cover to allow for spring cleaning of resident rooms. There is a large housekeeping room for the secure storage of cleaning trolleys, equipment and chemicals.</p> <p>All staff have completed chemical safety and infection control education. Laundry and cleaning audits were completed as per the Ryman programme. The chemical providers monitor the laundry and cleaning process.</p> <p>Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Orientation includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The facility has an approved fire evacuation plan and fire drills take place six-monthly. The last fire evacuation drill occurred on 1 October 2020. Smoke alarms, sprinkler system and exit signs are in place. The fire system within the facility is currently being upgraded to meet new standards and regulations, however, the current system remains compliant.</p> <p>Emergency lighting is in place, which runs for at least two hours. The facility has an on-site diesel generator to run essential services. There is a civil defence kit located in a central location. Supplies of</p> |

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| | | <p>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.</p> <p>The call bell system is evident in resident's rooms, lounge areas and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advised that they conduct security checks inside at night, in addition to an external contractor who checks the external environment.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight.</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 appropriate to the size and scope of the service.</p> | FA | <p>The infection prevention and control programme is appropriate for the size and complexity of the service. There is an infection prevention and control responsibility policy that included a chain of responsibility and an infection prevention and control coordinator's job description. The clinical manager is responsible for infection prevention and control at the facility and has previous experience in infection control coordination.</p> <p>The infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet two-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and directed via the TeamRyman calendar. The facility had developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. Notices are displayed on entry to the facility reminding visitors not to visit if they are unwell.</p> <p>Due to current Covid-19 guidelines, all visitors and contractors must complete a wellness declaration and sign into the facility. There were adequate supplies of infection control equipment sighted in the case of outbreaks. A good supply of hand gel, masks and aprons are available.</p> <p>There has been one gastro outbreak at the facility since the last audit, in November 2018. This was reported, documented and managed well. Debrief meetings were held post outbreak.</p> |
| <p>Standard 3.2: Implementing the</p> | FA | <p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control updates. Ryman is a member of</p> |

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| <p>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>Bug Control. The infection control team is representative of the facility. Resident care plans reviewed included comprehensive documentation for any known infections.</p> <p>External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>The requirements during the Covid-19 lockdown and practices at all different levels have been adhered to. There are folders containing all information and processes for each level of lockdown. During the lockdown period, staff were provided with separate changing facilities. All staff had very clear guidelines on infection control and laundering of uniforms. Residents adhered to the isolation and temperature checking. Activities were set up in hallways so residents could participate while adhering to social distancing. Education sessions were provided for hand washing and infection control was held in 23/3/2019, 10/4/2019 and 5/3/2020. The COVID GO kit was implemented September 2020 and 2x COVID GO drills which also included the correct techniques of donning and doffing personal protective equipment (PPE) was held in February 2021. The facility continues to maintain current regulations, ensuring all visitors complete the electronic wellness declaration and sign in. Staff interviewed stated they felt well looked after and were well informed of changes during the Covid-19 period.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection</p> | FA | <p>The infection prevention and control officer (Clinical Manager) 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</p> |

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| <p>control to all service providers, support staff, and consumers.</p> | | <p>training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. Online training was provided around PPE, infection control and handwashing was provided as required during 2020 with self-directed learning and via a full facility meeting.</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 policy described the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined two-monthly infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer use the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection rates are benchmarked across the organisation.</p> |
| <p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>The restraint approval process is described in the restraint minimisation policy. The service is restraint and enabler free. The clinical manager is the restraint coordinator and has a job description that defines the role and responsibility of the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Six monthly restraint meetings occur. All restraint and enablers are reported to TeamRyman monthly. Training is provided to staff around restraint, enablers and challenging behaviours as part of the education programme.</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.

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | CI | <p>There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.</p> <p>Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (e.g., quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited.</p> | <p>The achievement of the rating that the service provides an environment that encourages ongoing quality improvement initiatives is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example: The service implemented a project around keeping falls rates below the group average. The ongoing action plan was evaluated quarterly. New interventions have been implemented where required. Regular evaluations for the last two years identify they have met their goal of keeping falls low, remaining below the group average with the exception of one month.</p> |

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| | | <p>Benchmarking reports are generated throughout the year to review performance (monthly and six-monthly clinical indicator report). A quality improvement plan register is utilised and documents actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.</p> <p>There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Frances Hodgkins is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified</p> | |
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End of the report.