

Possum Bourne Retirement Village Limited - Possum Bourne 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:	Possum Bourne Retirement Village Limited
Premises audited:	Possum Bourne Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 June 2021 End date: 30 June 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	117

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Possum Bourne is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia levels of care for up to 122 residents in the care centre and rest home level of care for up to 30 residents in the serviced apartments. On the day of audit there were 117 residents. The service is managed by an experienced village manager and clinical manager/registered nurse. Both are supported by regional manager and other experienced personnel at Ryman Christchurch. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and a general practitioner. The service has been actively working on reducing the number of falls, reducing turnover of staff and improving communication with service users. Feedback from residents and families was very positive about the care and services provided.

There are three areas of continuous improvement awarded around reducing residents' falls, food services and maintaining a restraint-free environment.

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.

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents, and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. A 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. Quality improvement plans 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 implemented for new staff. Ongoing

education and training include in-service education and competency assessments. Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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There is an information/welcome pack that includes information on each level of care. Registered nurses are responsible for initial assessments, risk assessments, interRAI assessments and development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, were individualised and evaluated six-monthly. The general practitioner reviews residents on admission and at least three- monthly. Other allied health professionals are involved in the care of residents including (but not limited to) the physiotherapist and dietitian.

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

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

Meals are prepared on-site. The project delicious menu is designed by a dietitian at organisational level and provides meal options including vegetarian. Individual and special dietary needs are catered for. There are nutritious snacks available 24 hours in the dementia unit.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

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

Restraint minimisation and safe practice

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

Standards applicable to this service fully attained.

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

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.
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The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control coordinator leads integrated meetings with the health and safety team. The infection prevention and control register are used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. COVID-19 lockdown was well-managed, and precautions remain in place as per current guidelines.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	44	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Seven managers (one village manager, one clinical manager, one regional manager, three unit coordinators/registered nurses (RNs), one unit coordinator/enrolled nurse (EN); and twenty staff (one assistant to the manager, four registered nurses (RNs); seven caregivers working on the AM and PM shifts (two rest home, two hospital and two dementia care, one serviced apartments), three activities staff, one maintenance, one cook, one receptionist/health and safety representative, one laundry coordinator, one cleaner) confirmed their understanding of the Code and its application to their specific job role and responsibilities. Staff receive training about the Code, which begins during their induction to the service. This training continues through the mandatory staff education and training programme, which includes competency questionnaires.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are	FA	Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. General consents were sighted in the eleven files reviewed (six hospital including one respite, two rest home including one resident in the serviced apartments and three dementia). Specific consents were viewed for wound photographs and influenza and Covid vaccines. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Informed

provided with the information they need to make informed choices and give informed consent.		<p>consent training was held Feb 2019.</p> <p>Resuscitation status was signed by the competent resident and witnessed by the general practitioner (GP). Where the resident is unable to make a decision, the GP makes a medically indicated not for resuscitation in consultation with the enduring power of attorney (EPOA). The EPOA for the three-dementia level of care residents had been activated. Copies of EPOA and activation status are available on the resident's files.</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 eleven long-term resident files under the ARCC had been signed within a timely manner. There was a short-term agreement in place for the respite care resident.</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 interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on the resident's family/whānau and chosen social networks. Information is available on notice boards regarding HDC advocacy services. Interviews with caregiver staff and the village manager supported the caregiver's role as advocates for the residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Residents are encouraged to integrate into village activities. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented. The village manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. The village manager maintains an up-to-date (electronic) complaints register. Concerns and complaints are discussed at relevant meetings. No complaints were lodged in 2020 and four complaints have been lodged in 2021 (year to date). All four complaints were reviewed. Acknowledgement of the lodged complaints and an investigation and communication with the complainants were included in the register. All four complaints are documented as resolved.</p> <p>Interviews with residents and relatives confirmed they were provided with information on the complaints</p>

		process.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Five relatives (one hospital and four dementia) and nine residents (five rest home and four hospital) stated they were provided with information on admission which included information about the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager confirmed her door is open to visitors. Both she and the clinical manager described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman policies that support resident privacy and confidentiality are being implemented. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors are closed while care is being undertaken. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences including cultural, religious, social and ethnic are identified during the admission and care planning process with evidence of family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings. Caregivers interviewed described how choice is incorporated into resident cares. There are policies, procedures and training in place that address elder abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Māori health plan is being implemented. 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. Links are in place with a designated kaumatua from the Papakura marae. The village manager reported having a meeting several weeks ago with the kaumatua to discuss future Matariki activities planned for the village and ways residents can engage more with Maori cultural values and beliefs. A kapahaka group from the local college visits residents. Other community representative groups are available as requested by the resident/family. There were no residents who identified as Māori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-</p>

Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that the residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account the residents' values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. All staff are required to read and sign the Ryman professional boundaries policy as part of the new employee induction process. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Managers provide guidelines and mentoring for specific situations. Interviews with staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	All Ryman facilities have a master copy of policies, which are developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the team Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations or non-conformances are identified. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. A physiotherapist is onsite five hours a day, five days a week and is assisted by a physiotherapy assistant (four hours a day, five days a week). A general practitioner (GP) from the local family health centre visits the facility daily (Monday-Friday) with on-call service provided after hours.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Fifteen incident forms selected for review evidenced that family are informed of accident/incidents. Relatives interviewed confirmed that they are informed when their family member's health status changes and/or if there has been an adverse event. Residents' meetings occur two monthly and family meetings take place six-monthly. The service produces a seasonal (hard copy) newsletter 'Possums Post' that is readily available to all residents, relatives and visitors to the facility. Care centre families are also provided with monthly email communication via the

		<p>'Care Connection' newsletter. The information pack and admission agreement include payment for items that are not subsidised.</p> <p>Residents interviewed confirmed they are welcomed on entry and are given time and explanation about the services and procedures. Specific and written information is provided to families about the unique aspects of the dementia unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Interpreter policy and contact details of interpreters is available. During the audit there were no residents who were unable to communicate in English. Picture cards have been used in the past for translation purposes.</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>Possum Bourne is a Ryman Healthcare retirement village providing rest home, hospital and dementia levels of care for up to 122 residents in the care centre. The facility is also certified to provide rest home level of care in 30 serviced apartments. The facility has four levels with care beds located on three of the four floors. The second level has two 20-bed secure dementia care units, the third level has 41 rest home beds (certified as dual-purpose), which includes one double room for a couple if needed; and the fourth level has 41 hospital beds (certified as dual-purpose), which includes one double room for a couple if needed. The double rooms were not occupied during the audit. Serviced apartments are spread across the four floors.</p> <p>On the day of audit, there were 117 residents: 26 at rest home level of care in the care facility and 1 rest home level resident in a serviced apartment, 51 residents at hospital level of care including one resident on respite, and 39 residents at dementia level of care (20 residents in one unit and 19 in the other unit). All remaining residents were under the age-related residential care contract (ARCC).</p> <p>Quality objectives and quality initiatives are set annually and are regularly reviewed. Evidence in the full facility staff meeting minutes reflects discussions around these objectives.</p> <p>The village manager is a registered nurse who was appointed to her role in September 2019. Prior to this she was the clinical manager. She holds an advanced diploma in nursing and a post graduate certificate in long term health conditions. She is supported by an assistant to the manager (non-clinical), who carries out administrative functions and an experienced clinical manager who oversees all clinical care. The clinical manager is supported by four-unit coordinators, one for each level of care. A regional manager oversees operations at Possum Bourne and was available during the audit.</p> <p>The village manager and clinical manager have attended in excess of eight hours of professional development per year relating to managing an aged care facility.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager (RN) is second in charge during the temporary absence of the village manager with support from the regional manager and Ryman management 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>The Ryman quality management system is fully implemented at Possum Bourne. Quality data and outcomes are reported across the various meetings, including the full facility, RN/clinical and team Ryman (quality) meetings. Meeting minutes include discussions relating to the key components of the quality programme including (but not limited to) policy reviews, internal audits, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Interviews with staff confirmed their understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman Christchurch (head office). Policy documents are developed in line with current best and/or evidenced based practice. Staff are informed of changes/updates to policy at relevant staff meetings. In addition, a number of core clinical practices include staff comprehension surveys that staff are required to complete to evidence competency. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room.</p> <p>Relative and resident surveys were last completed in February 2021. Results have been collated with annual comparisons for each service. No areas were identified that required the implementation of a QIP. Residents and relatives are informed of the outcomes of surveys in the two monthly residents' meetings and six-monthly relative meetings. An annual internal audit schedule that has been implemented. Internal audit summaries and QIPs are completed where a non-compliance is identified (<90%).</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A gradual reduction in falls resulting from the implementation of a range of strategies has resulted in a rating of continuous improvement.</p> <p>Health and safety policies are implemented and monitored as evidenced in the monthly health and safety meetings. The village manager has overall responsibility for the health and safety programme. A health and safety representative (receptionist) was interviewed during the audit. The service documents and</p>

		<p>analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. The hazard registers for generic and specific hazards are reviewed a minimum of annually. The internal audit programme is linked to health and safety (eg, food safety audits, emergency call bell audits, environmental audits, fire safety audits, waste management audits). Staff document hazards and near miss events in a designated book that is held at reception. All staff complete health and safety training during their induction to the facility. Reception staff and/or maintenance staff are responsible to orientating external contractors through the Assure electronic system.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action(s) required. A review of fifteen incident/accident reports (witnessed and unwitnessed falls, episodes of challenging behaviours, pressure injury, medication error) from across all areas of the service identified that all are fully completed and include follow-up by a RN. The clinical manager is involved in the adverse event process and signs off on all adverse events.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Section 31 reports have been completed since the previous audit pertaining to notification of pressure injuries and one unexpected death.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (one clinical manager, three unit coordinators/RNs, one staff RN, four caregivers, one assistant to the manager, one head chef, one kitchen assistant, one activities coordinator, one receptionist/health and safety representative) included a signed employment contract, job description, police check, induction paperwork relevant to the role the staff member is in, application form and reference checks. All files reviewed of employees who have worked for one year or more included evidence of annual performance appraisals. A register of RN and enrolled nurse (EN) practising certificates are maintained within the facility. Practising certificates for other health practitioners are also retained to provide evidence of their registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Educational courses offered include in-services, competency questionnaires, online learning and external professional development.</p>

		<p>Approximately 100 caregivers are employed. Sixty-one have achieved their level three (or equivalent) Careerforce qualification and ten have achieved their level four qualification. Twenty-two caregivers work in the dementia unit. Eight caregivers have completed their Careerforce dementia qualification or equivalent. Ten caregivers are progressing through their dementia unit standards and have been employed for less than eighteen months. Four caregivers have been employed less than six months and have not signed a training agreement yet to complete their dementia qualification.</p> <p>Registered nurses are supported to maintain their professional competency. RNs attend regular (two-monthly) journal club meetings and are enrolled and working towards their professional development recognition portfolios (PDRP) with two RN staff having completed the PDRP programme. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including (but not limited to) infection control, medication and insulin competencies. At the time of the audit there were 24 RNs and one EN employed at Possum Bourne. Eight RNs (including the clinical manager) have completed interRAI training.</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. The village manager, assistant to the manager and clinical services manager/RN work Monday – Friday. Staffing ratios are based on 1 staff:7 residents AM shift and 1 staff:10 residents PM shift in the dementia wings; 1:5 for hospital level residents and 1:10 for rest home level residents.</p> <p>The hospital wing (occupancy 39 hospital residents) is staffed with a unit coordinator/RN Tuesday - Saturday. Two staff RNs cover the AM and the PM shifts, and one RN covers the night shift. The AM shift is staffed with four long shift and four short shift caregivers, the PM shift is staffed with two long shift and four short shift caregivers and the night shift is staffed with three long shift caregivers. Activities staff are rostered seven days a week from 9:30 am – 4:30 pm. One fluid assistant covers the AM shift (short shift) seven days a week and a physiotherapy assistant cover the AM shifts five days a week (short shift). A PM shift lounge carer is rostered from 4.00 pm – 8.00 pm seven days a week.</p> <p>The dementia unit is split into two 20 bed units with an occupancy of 39 residents during the audit. The nursing station is placed centrally between the two units. A designated unit coordinator/RN works the AM shift (Sunday - Thursday). One RN is rostered on the AM shift (with a second RN on the days the unit coordinator is off) and one RN covers both units during the PM shifts. The AM and PM shifts are staffed with one long and one short shift caregiver on each unit. An additional lounge assistant is rostered on the AM and PM shifts. The night shift is staffed with three long shift caregivers, one who is a designated senior caregiver.</p> <p>The rest home wing (26 rest home level and 12 hospital level residents) is staffed with one-unit coordinator/RN Tuesday – Saturday. One RN is rostered on the AM and PM shifts and a second RN is</p>

		<p>rostered on the two days that the unit coordinator is not available. The AM shifts are staffed with four short and two long shift caregivers, the PM shifts are staffed with two long and three short shift caregivers and the night shift is staffed with three long shift caregivers, one who is a senior caregiver. Efforts are underway to hire a night shift RN.</p> <p>Service apartments (one rest home level resident) is staffed with one-unit coordinator/enrolled nurse (EN) five days a week. A senior caregiver is rostered on the two days that the unit coordinator is not available. In addition, the AM shift is staffed with two short shift caregivers. Activities staff are available Monday – Friday. The PM shift is staffed with two short shift caregivers to 9.00 pm. After 9.00 pm, a designated caregiver in the rest home wing covers the serviced apartments via a pager system. Any rest home level residents in the serviced apartments are clearly identified on the resident register and are communicated to the senior rest home level caregiver during handover.</p> <p>A 'cover pool' of staff (RN cover 116.5 hours per week, caregiver cover 89 hours per week) are additional staff that are added to the roster to cover staff absences.</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 all 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 that there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</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</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has an information pack available for residents/families at entry including specific information on dementia level of care and the safe environment.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term care.</p>

been identified.		
<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. All relevant information is documented and communicated to the receiving health provider or service including advance directives or medical care guidance documentation. The facility uses the 'yellow envelope' system. Transfer notes and discharge information was available in the hard copy resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All medications are stored safely in each unit. Registered nurses and senior caregiver's complete annual medication competencies and education. Registered nurses complete syringe driver training. Medication reconciliation of monthly blister packs and as required blister packs are checked by an RN with the signature on the back of the blister pack. There were four residents self-medicating (inhalers and one nasal spray) with a self-medicating assessment in place that had been reviewed three-monthly by the GP. The medication fridge temperatures are taken weekly in all units and are within the acceptable range. Medication room air temperatures are taken and recorded daily. All eye drops in use were dated on opening.</p> <p>The service uses an electronic medication system. Twenty-two medication charts were reviewed (twelve hospital including one respite, four rest home and six dementia care). All medication charts had photographs and allergies documented. Medication charts had been reviewed at least three-monthly by the GP (except for the respite care resident). Records demonstrated that regular medications were administered as prescribed. As required medications had the indication for use documented. The effectiveness of as required medications was recorded in the electronic medication system and in the progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	CI	<p>All food and baking are prepared and cooked on-site. The kitchen is located in the service area on the ground floor. The lead chef (interviewed) is supported by two other chefs, two, cook assistants and two kitchenhands each day. All food services staff have completed food safety on-line training and chemical safety.</p> <p>Project "delicious" is a four weekly seasonal menu with three menu choices for the midday meal and two choices for the evening meal, including a vegetarian option. The seasonal menu has been designed in consultation with the dietitian at an organisational level. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes including weight loss. All dietary requirements and likes and dislikes are accommodated. Pure foods are used for pureed meals and as a base for soups and</p>

		<p>other suitable foods. Lip plates are available to encourage resident's independence with meals. Meals are delivered to the units in hot boxes. Special diets are plated and labelled in the kitchen. Nutritious snacks such as sandwiches, muffins, fruit and yoghurts are delivered to the dementia care unit daily and there was plenty of snacks, fluids and foods available in all the units. Each unit has a functioning satellite kitchen from where the breakfast is served.</p> <p>There is a current food control plan issued 16 March 2021. Temperatures are taken and recorded for fridges, freezer, cooking and cooling and incoming goods. All foods were stored correctly, and date labelled. The chemicals are stored safely, and the chemical provider conducts checks on the dishwasher regularly. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings and direct contact with the food services staff. Resident and relatives interviewed spoke positively about the choices and meals provided. The resident survey result for food services has improved from 3.38 in 2020 to 3.45 2021.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>In the files reviewed, an initial assessment and relevant risk assessment tools had been completed on admission for all residents including the respite care resident. The outcomes of interRAI assessments and triggers for long-term residents were reflected in the long-term care plans reviewed. Additional assessments such as (but not limited to) behavioural, pain, wound and physiotherapy assessments were completed according to need. There are a number of assessments completed that assess resident needs holistically such as cultural and spiritual and activities assessments. The assessments generate interventions and narrative completed by the RNs that are transferred to the myRyman care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan evaluation. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met in all eleven resident files reviewed. The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall, likes and dislikes. There were behaviour management plans in place for the three dementia care resident files reviewed. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Relatives interviewed confirmed they were involved in the care planning process and signed the care plan acknowledgment form (kept in hard copy files). Other information gathered from allied health professionals and discharge summaries are used to develop care plans. Care plans included involvement of allied health professionals in the care of the resident such as the GP, physio, geriatrician and dietitian. This was integrated into the electronic myRyman individualised record.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. The care plans are updated with any changes to care and required health monitoring interventions for individual residents are scheduled on the RN or caregiver electronic work log.</p> <p>Wound assessments, treatment and evaluations were in place for 14 wounds (four rest home, seven hospital and three dementia care). There were skin tears, blisters, scratches, chronic venous leg ulcer and one surgical wound. There are five pressure injuries, one stage 1, three stage 2 and one non-facility acquired unstageable. The unstageable had been reported on a S31. All wounds are linked to the care plans. Photos have been taken where relevant. Each floor has a wound champion. Ryman wound champions attend zoom meetings with the Ryman wound nurse specialist. The wound champions have attended wound care and pressure injury prevention education. Referrals are made as necessary to the GP, dietitian and wound nurse specialist. The service has adequate pressure relieving resources available.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring requirements are scheduled on the electronic work log and used to monitor a resident's progress against clinical/care interventions for identified concerns or problems. Monitoring forms reviewed included (but not limited to) blood pressure, weights, blood sugar levels, pain, behaviour, repositioning charts, bowel records, food and fluids, intentional rounding, restraint and neurological observations</p>

		Intentional rounding is determined by the residents need including toileting, whereabouts of residents or falls risk.
<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>	FA	<p>The service employs an activity team of three diversional therapists (one in rest home, dementia care unit and serviced apartments). There is a hospital diversional therapist (DT) starting in July. In the meantime, activity assistants and caregivers have been running the hospital programme. The DTs are supported by lounge assistants in all units. The rest home residents in the serviced apartments can choose to attend the rest home or serviced apartment programme. The Engage programme is from Monday to Friday. Weekend activities are set by the DT's but run by lounge assistants with the help of other caregivers. There are ample resources available.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including (but not limited to); Triple A exercises, board games, news and views, make and create, memory lane, gardening, village walks, small group walks, men's club, movies, indoor bowls, music, happy hour and sensory activities including pet therapy, baking and one on one pampering. Residents enjoy watching or participating in dancing during entertainment and musical events. There are events for the ladies such as high tea and events for the men's group including barbeques and competitions. One townhouse resident regularly plays the piano for residents, another plays the keyboard and another the piano accordion. The village centre hosts integrated activities and events. There are weekly entertainers with happy hour in each unit. Catholic church services are held every Friday and interdenominational services every Tuesday.</p> <p>There are weekly van outings and scenic drives for all residents. The van has wheelchair access. Residents are encouraged to maintain community links. Themed events and festive occasions are celebrated. Preschools, schools and Duke of Edinburgh students visit.</p> <p>Resident life experiences and an activity assessment is completed for residents on admission. The resident/family are involved in the development of the activity plan. An identity map is completed by the family for all dementia care residents and the information used to develop the individual activity plan. The activity plan is incorporated into the myRyman care plan and evaluated six-monthly with the MDT review. Residents/relatives can feedback on the programme through the two monthly resident and relative meetings and surveys. The residents/relatives interviewed were satisfied with the activity programme. Activities were observed in each of the units with good resident attendance and participation.</p>
Standard 1.3.8: Evaluation Consumers' service delivery	FA	All initial care plans of long-term residents had been evaluated at three weeks prior to the development of the long-term care plan. Nine files of residents who had been at the service six months identified that long-term care plans had been evaluated by registered nurses. One long-term resident's care plan was not due

plans are evaluated in a comprehensive and timely manner.		<p>for a six-monthly evaluation. The respite resident's plan was not required to be evaluated. Care plans had been updated with any changes to health and care.</p> <p>Written evaluations describe the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. The multidisciplinary (MDT) review includes the RN, caregivers, DT, GP, physiotherapist, resident, relative and any other health professionals involved in the resident's care. A record of the MDT review is kept in the resident hard copy file. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, the resident was referred for reassessment for a higher level of care from rest home to hospital level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, DHB nurse specialists, older persons service, mental health services, the hospice and contracted allied professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Relevant staff have completed chemical safety training. Gloves, aprons, and goggles are available for all care staff and laundry/housekeeping staff and available in sluice rooms (two on each floor) and laundry/housekeeping areas. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing while carrying out their duties. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets and product information is available. The chemical provider monitors the effectiveness of chemicals and provides chemical safety training.</p>
Standard 1.4.2: Facility Specifications	FA	<p>The building has a current warrant of fitness till 6 September 2021. The care centre is across three levels and the serviced apartments are on all four floors. There are lifts between floors.</p>

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		<p>The maintenance person works full-time. The facility is currently recruiting a support person. The maintenance register is checked daily for repairs and requests and signed off as requests are addressed. There is a monthly planned maintenance schedule which covers internal and external maintenance, resident equipment checks and calibrations, testing and tagging of electrical equipment. Resident hot water temperatures are checked, and records demonstrate the temperatures were below 45 degrees Celsius. Contracted plumbers and electricians are used as required.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space in the rest home and hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. There are two double rooms. Both currently have only one resident. There is provision for privacy curtains if occupied by two residents. The ensuites are spacious and safely accessible with the use of a hoist as demonstrated on the day of audit. There is a call bell at the head of each bed space.</p> <p>There is a separate gardening and grounds team. Residents are able to access outdoor areas safely or with supervision.</p> <p>There is secure entry/exit to the two dementia 20-bed units. Each unit has access to a fenced courtyard area with seating and shade. Residents are regularly taken out to the gardens in the grounds for walks.</p> <p>Care staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms (including the serviced apartments) have full toilet/shower ensuites. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Non-slip flooring and handrails are in place. Care staff interviewed confirmed they maintain the resident's privacy when undertaking personal cares.</p>
Standard 1.4.4: Personal Space/Bed Areas	FA	<p>Apart from the two double rooms all other rooms are single. There are 30 serviced apartments certified for rest home but currently only one rest home resident. All bedrooms across the facility have ensuites. All</p>

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		serviced apartments have a lounge, ensuite and separate bedroom. All bedrooms and ensuites across the rest home/hospital and dementia units are spacious for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The hospital and rest home units have a large open-plan dining area with kitchenette and open plan lounge area. Seating is arranged to allow large group and small group activities to occur. Both units have a family room and quiet lounge. All serviced apartments also have their own spacious lounge and kitchenette as well as communal dining areas. The village centre is on the ground floor with communal areas available to care centre residents including the hairdresser and beauty rooms, reflection room, library, gym and swimming pool.</p> <p>Each dementia unit has an open-plan living area. Each living area is spacious with a separate dining area. The open plan areas allow for quiet areas and group activities. The hallways and communal areas allow maximum freedom of movement while promoting the safety of residents who are likely to wander. There are alcoves with memorabilia throughout the units. There is free access to the safe outdoor gardens from each unit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The laundry is located in the service area on the ground floor. The laundry has an entry and exit door with defined clean/dirty areas. All linen and personal clothing is laundered on-site. There is a laundry coordinator who works full time and two workers who work four hours daily plus another who works 7-10pm. There are large commercial washing machines, sluice machine, delicate machine and dryers. The clean side has space for folding washing, ironing and a labelling machine. There is minimal unlabelled/unclaimed clothing. The laundry coordinator takes photos of any unlabelled/unclaimed clothing and advertises these online. There is a large linen storeroom.</p> <p>The service has a secure area for the storage of cleaning trolleys and chemicals. There is a team of cleaners who cover seven days a week, five hours a day. Cleaner's trolleys (sighted) were well equipped. A chemical dispensing unit is used to refill chemical bottles. All chemical bottles have the correct manufacturer's labels. Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Trolleys are stored in locked cleaners' cupboards when not in use.</p> <p>Feedback is received through resident meetings, results of internal audits and surveys. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas. Residents and relatives were satisfied with the laundry and cleaning services.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster policies and procedures to guide staff in managing emergencies and disasters. The new staff induction programme covers emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The retirement village has access to three diesel generators in the event of a power failure. There are civil defence supplies centrally located. Supplies of stored drinkable water is stored to ensure that there is a minimum of three litres available for each resident over three days. There is also a minimum of three days of food storage available. There are alternative cooking facilities available with gas barbeques and gas cooking in the kitchen.</p> <p>The facility has an approved fire evacuation plan and fire drills take place six-monthly. The call bell system is evident in residents' rooms, lounge areas and toilets/bathrooms. Residents are provided with alarm pendants in addition to access to a call bell next to their bed and in their ensuites. There are closed circuit cameras strategically placed throughout the facility. Staff advise that they conduct security checks at night, in addition to an external contracted company.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. Heating is by a HVAC system and this is checked three monthly by the contractor. There are also heat pumps in the communal areas. There are external windows in resident rooms and communal areas with plenty of natural sunlight. The facility is a non -smoking environment.</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. The clinical manager (registered nurse) is the infection control officer. The infection prevention and control coordinator job description outlines the role and responsibilities. The infection prevention and control programme are linked into the quality management system. Infection prevention and control is part of health and safety and they 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. Possum Bourne staff have developed links with the GPs, local laboratory, Bug Control and public health departments.</p> <p>There are notices at the entrance reminding visitors not to visit if they are unwell. There is Covid-19 screening in place for all visitors.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control programme are linked into the quality management system. Infection prevention and control is part of health and safety and they meet two monthly. The facility meetings also include a discussion of infection prevention and control matters. The facility has developed links with the GPs, local laboratory, Bug Control and the public health department.</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 on each floor in the case of outbreaks. A good supply of hand gel, masks and aprons are readily available. There is liquid soap dispensers and single use paper hand towels in all resident rooms.</p> <p>A COVID-19 go kit was implemented by head office in September 2020, and COVID GO drills were conducted. Plans are in place if there were an outbreak around staffing bubbles, changing uniforms, strict controls around housekeeping, laundry and kitchen services. Security has been implemented to screen all visitors and contractors entering the building and ensuring wellness declarations are completed.</p> <p>A COVID-19 preparedness folder has been developed which clearly indicates essential contact numbers of key management and clear easy to follow instructions for staff to follow if covid19 is identified in the facility. There is a flow chart with instructions of what to do in the first 30 mins, and stages for the first 24 hours. A self-preparedness tool has been implemented and a 'walk through' of the facility and a stock take of PPE is completed at least monthly. The updated pandemic plan and isolation plan is included in the folder. Updated information is sent to staff on Facebook Chatter.</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</p>	FA	<p>There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. Policies and procedures, and the Pandemic plan have been updated to reflect COVID-19.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. There was extensive training provided around combatting COVID-19 and infection control education separate to COVID-19 is held twice yearly.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator.</p> <p>An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the two monthly health and safety meetings. Any trends are analysed and solutions discussed and implemented. All meetings held include discussion on infection prevention control. The infection control programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit, the facility was not using any restraints or enablers.</p> <p>Restraint policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. Staff training has been provided around maintaining a restraint-free environment as well as strategies to manage challenging behaviours and minimise falls.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Robust systems are in place for the collection, analysis and evaluation of quality data. A range of data is collected across the service using V-Care, an electronic data management system. Data is collated and analysed with comprehensive evaluation reports completed. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other similar service types within Ryman facilities. Communication of results occurs across the range of meetings. Data collated is used to identify any areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is collected around (but not limited to): falls, skin tears, pressure injuries	Falls data across the care centre has steadily reduced from 13.56 falls/1000 bed nights in January 2020 to 8.80 falls/1000 bed nights in May 2021. Strategies implemented to achieve this positive outcome include the following: physiotherapy involvement with residents at risk of falling has increased with physiotherapy hours increased from 15 to 20 hours per week (July 2020); falls charts are regularly displayed to heighten staff awareness of residents at risk of falls; hourly intentional rounding is implemented for residents at high risk of falls and for vision impaired residents; staff are requested to complete ‘step back’ cards to reflect on why a particular resident has fallen; caregivers handover to their buddy when leaving the floor; lounge carers are provided with relief cover when leaving the lounge; bed and floor sensor mats are regularly checked to ensure that they are working properly; resident footwear is checked regularly; and residents are encouraged to attend the Ryman Triple A exercise classes.

		and infections.	
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>Project 'delicious' was introduced to all Ryman facilities. This provides a dietitian approved four weekly seasonal menu with three menu choices for the midday meal and two for the evening meal including a vegetarian option. They also introduced Pure foods for puree meals and as a base for soups and other suitable foods. In February 2020 as a follow up to this the facility commenced a project where they looked at 1). Exceeding resident expectation for meal service 2). Providing residents with a stable nutritious diet that includes variety 3). Offering residents the opportunity to make their own choices re likes and dislikes 4). Providing a satisfying and positive dining experience as well as an enjoyable social occasion 5). Improving the quality of the service of meals.</p>	<p>Each week the leadership team completes weekly food reviews noting positive and negative feedback on the meals and meal service. The activities staff have also introduced discussions with residents about meal choices. Fruit smoothies and protein smoothies are now available morning and afternoon. All these initiatives will be ongoing. Kitchen and dining room staff have received training on meal service. The facility has created and reconfigured seating arrangements. Residents who like social interaction with other residents are encouraged to sit at one table. They have also introduced a men's table. The table plan and table settings have been changed to promote a nicer ambience for dining. In April this year soft background music was introduced in the dining areas. The facility is currently looking at introducing a texture modified food specific menu for puree diets.</p> <p>This has led to improved weekly food reviews. The resident survey result for food services has improved from 3.38 in 2020 to 3.45 in 2021. There is less food waste on plates -residents are enjoying their meals more and finishing their meals. There is opportunity to try new foods. There is improved socialisation-residents chat with their neighbours about their meal choice. Staff have commented that there is a happier atmosphere in the dining room at mealtimes. It has provided residents with the opportunity to make a choice in another area of their lives-this promotes independence freedom of choice and value as a person.</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive</p>	CI	<p>Possum Bourne has been restraint-free since January 2020.</p>	<p>The facility has maintained a restraint-free environment for the past six months. A restraint committee meets twice per year to evaluate the quality initiative of remaining restraint-free. Strategies implemented include regular staff education on maintaining a restraint-free environment, explaining to staff the risks of restraint, what constitutes restraint, interventions, strategies, and accountabilities. Residents and families are well-informed at entry to the service regarding the care centre's goal of maintaining a</p>

option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.			restraint free environment and the benefits this has for their residents. Falls prevention strategies are implemented (link CI 1.2.3.6) which help to reduce the need for restraint; residents displaying agitated behaviours are provided with additional companionship, may receive hand massages to help calm them, and are provided with regular fluids and toileting.
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End of the report.