

William Sanders Retirement Village Limited - William Sanders 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:	William Sanders Retirement Village Limited		
Premises audited:	William Sanders 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: 8 July 2021	End date: 9 July 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: 60			

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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

William Sanders is part of the Ryman Group of retirement villages and aged care facilities. The facility opened in October 2020 and provides rest home, hospital and dementia level care for up to 112 residents in the care centre and rest home level care for up to 30 residents in the serviced apartments. On the days of the audit there were 60 residents receiving care in the care centre including one resident at rest home level in the serviced apartments.

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

The village manager (non- clinical) has been in the role since 2019. He is supported by a clinical manager (registered nurse) who has been in the role for a year and has previous experience within Ryman. The management team are supported by unit coordinators, a regional manager and support staff at head office. The residents, relatives and the nurse practitioner interviewed spoke positively about the care and support provided. Ryman have robust quality and risk systems which have been implemented at William Sanders.

This audit identified the service is meeting the health and disability standards.

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 are implemented to support residents' rights, communication and complaints management. The service complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. 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. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

Standards applicable to this service fully attained.

The village manager, clinical manager and unit coordinators are responsible for the day- to-day operations. Services are planned, coordinated, and appropriate to the needs of the residents. An annual quality plan is being implemented. A comprehensive quality and risk management programme is in place and goals are documented for the service with evidence of regular reviews. 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.

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.

Residents receive appropriate services from suitably qualified staff. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents. The integrated residents' files are appropriate to the service type.

Continuum of service delivery

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

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

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

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

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building has a certificate for public use. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. All bedrooms have ensembles. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas and balconies 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.

There are currently no restraints or enablers in use. 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. There is a restraint register for restraints and enablers when in use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control committee meet six-weekly. All infections are captured through the electronic resident management system, collated and analysed for trends by the infection control coordinator (clinical manager). A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. Education around infection control is included in the annual education plan and extra training is provided as required. All infection control policies, procedures and the pandemic/ emergency plan have been updated to include Covid 19. Resource folders are available to guide staff on the different lockdown level guidelines. Adequate supplies of personal protective equipment were sighted during the audit. There have been no outbreaks in the facility since opening in October 2020.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code).</p> <p>Discussions with the village manager, clinical manager/RN, regional manager, and 20 clinical staff (eight caregivers who work across all service levels, four registered nurses (RNs), four-unit coordinators, one activities coordinator and three diversional therapists) confirmed their familiarity with the Code. Non-clinical staff including one laundry coordinator, one lead chef, one housekeeper, one receptionist/ health and safety officer, and a maintenance person were also familiar with the Code.</p>
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. General consents were sighted in the eight files reviewed (three hospital level, three rest home including one resident in the serviced apartments and one resident on respite care and two dementia level). Specific consents were viewed for wound photographs, influenza and Covid vaccines. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Informed consent training is held annually.</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</p>

and give informed consent.		<p>consultation with the enduring power of attorney (EPOA). The EPOA for the two-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 seven 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 are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks. There is information on the noticeboards on each floor around 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>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, such as shopping and weekly outings. There are beautician and hairdressing salons on site. Residents are supported and encouraged to remain involved in the community and external groups, there are residents who are supported to be picked up by friends and relatives to attend church and reading groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception and on each floor on the noticeboards beside the lifts. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a box beside reception where people can put their complaint if they wish to remain anonymous.</p> <p>A complaint register is maintained. There has been one complaint received around care provision, which was investigated, education was provided, and the complaint was resolved. All documentation and correspondence are held on file and was completed in accordance to the timeframes set out by the Health and Disability commissioner.</p> <p>Complaints are linked to the quality and risk management system. Discussions with residents and relatives</p>

		confirmed that any issues are addressed and that they feel comfortable to bring up any concerns. Learnings from complaints are discussed at all facility meetings.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>An information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. There is the opportunity to discuss aspects of the Code during the admission process. Six residents (three rest home and three hospital) and six relatives (two rest home, two dementia and two hospital) interviewed confirmed that information around the Code had been provided to them. Large print posters of the Code and advocacy information are displayed on noticeboards on each floor (service level). The village manager or the clinical manager discusses the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with requirements of the revised Privacy Act and Health Information Privacy Code. A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible, and that residents' choices are encouraged. Staff have undertaken training on privacy and dignity in September 2020. Privacy, and code of rights are covered during induction to the service. The caregivers interviewed were fluent in describing how residents are treated with privacy and dignity and are encouraged to maintain independence as far as the resident is able.</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>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.</p> <p>Links are established with the district health board Māori health directorate who are available as a liaison for Māori residents and as a support to staff if required. There were no residents who identified as Māori on the days of the audit. Staff have completed education around cultural safety which included spirituality, effective communication. The sessions include scenarios where staff provide a solution.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All residents at the facility were able to speak and understand English.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The regional manager is available to support the management team if there is a concern around discrimination. Interviews with the managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries. Clear expectations are set out during the induction process. All staff sign 'house rules' and a code of conduct which addresses discriminations.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three- yearly. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (e.g., wound care, mental health) and staff education and training.</p> <p>There is a clear focus on providing a positive environment for staff, residents and relatives. There is a real sense of teamwork and the management work hard to ensure all members of staff feel valued as conformed during interviews with the management team, and staff. Quality data is collated monthly by the clinical manager, analysed for trends and discussed thoroughly at the clinical meetings, outcomes and corrective action plans are discussed at all facility meetings. Staff completed education in line with the Ryman education plan and using the online education platform. All staff are trained in first aid. As the resident admissions increase, there is ongoing planning for staffing, employment and managing rosters across the service levels.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members 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.</p> <p>Ryman have set up their own social media platform CHATTR which so far 80% of staff are active and 70% are engaged members. This platform is only available to Ryman staff and is used by staff socially and also utilised by management to inform staff of meetings, important changes, current infections and the like.</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>	<p>FA</p>	<p>Ryman William Sanders is located in Auckland. The facility opened on 5 October 2020 and provides care for a total of 142 residents across rest home, hospital, and dementia level care. The facility is built on a slope and provides services in the care centre over five floors. Level 3 (rest home) and level 4 (hospital) can accommodate up to 38 residents each. Both floors are dual-purpose. Level 3 (dual purpose unit) was opened first accommodating rest home and hospital level residents until occupancy allowed the opening of level 4. The special care (dementia care) unit on level 2 (opened 7 December 2020) provides care for up to 36 residents across two units, (only one 18-bed unit was open on the day of the audit). There are serviced apartments across five levels also, providing rest home level care for up to 30 residents.</p> <p>On the day of the audit there were 23 rest home residents (level 3) including a resident on respite, 24 hospital residents (level 4) and 12 residents in the special care unit (level 2), and one resident in the serviced apartments at rest home level care. All residents (excluding the resident on respite) were on the age-related residential care contract (ARRC).</p> <p>The Ryman overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is a Ryman strategic and quality plan and a TeamRyman quality programme. There are documented quality/health and safety goals. The 'kindness culture' is a theme of the service philosophy.</p> <p>The village manager has been in the role since April 2019 and has a background in senior management and leadership in education. He is supported by a regional manager who visits regularly and is available by phone when required for support and advice. The clinical manager has been in her role for a year and has had previous experience in unit coordinator roles across all service levels with Ryman since 2016. The managers are supported by an experienced unit coordinator (registered nurse) in each service level (rest home, hospital, and dementia) and enrolled nurse unit coordinator across the serviced apartments).</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>

<p>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 will step into the role with support from the unit coordinators and the regional manager.</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>Ryman William Sanders commenced implementing the quality and risk management system on opening that is directed by Ryman Christchurch (head office). Policies and procedures are reviewed at a national level and are forwarded through to a service level. Changes to policy and procedures are discussed at all meetings held in the facility. 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. Processes have been implemented 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 call bell response times, increase in challenging behaviours in dementia care and falls with injury. Action plans have been implemented and demonstrated ongoing improvements in these areas</p> <p>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. Staff who are unable to attend can join the meeting virtually through Zoom. Meetings are recorded and can be viewed by staff at their leisure. Discussions with the managers and staff and review of management and staff meeting minutes, demonstrated their involvement in quality and risk management activities.</p> <p>The resident and relatives annual survey has not yet been completed (opened in October 2020), this is planned for later in 2021. Monthly food service audits are completed which evidenced overall satisfaction of 4.5 out of a possible 5.</p> <p>Resident meetings are held two-monthly in the rest home and hospital levels, minutes of the meetings evidence residents are able to provide feedback and suggestions across all areas of service provision. A relative's</p>

		<p>meeting for all service level was held in May 2021, this was the first meeting held due to resident occupancy. Relatives interviewed appreciated the meeting and stated it as a good opportunity to confirm points of contact, complaint process, survey and feedback processes, and found the information provided to be useful, and they had the opportunity to ask any questions. Relatives interviewed confirm the management have an open-door policy and they can approach them at any time if they have a question or query.</p> <p>The health and safety officer and fire warden (administrator) were interviewed. The health and safety officer is responsible for completing monthly audits, ensuring checks of emergency kits, first aid kits around the facility are completed and stock is maintained. She has completed the health and safety induction, fire officer training and external risk management training. The health and safety committee is representative of all areas of the service. Meeting minutes evidence revision of all incidents and accidents, review of emergency procedures, new and ongoing hazards and risks, and implementation of the step back cards. 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. A current hazard and risk register is in place and easily accessible to staff. All new hazards have been logged onto the hazard log, which is reviewed each meeting, and then entered onto the register as appropriate. The register was last reviewed in June 2021.</p> <p>Individual falls prevention strategies are in place for residents identified at risk of falls. The service contract a physiotherapist 15 hours a week who assesses residents on admission and is involved in developing transfer plans. Care staff interviewed could describe falls prevention strategies as documented in myRyman care plan. Discussions with the managers and staff and review of management and staff meeting minutes, demonstrated their involvement in quality and risk management activities. Currently the service is reviewing data around falls and implementing fall prevention strategies, including provision of education sessions around fall prevention and reviewing care plans of residents at high risk of falling.</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, corrective action to minimise and debriefing. Individual incident reports are completed electronically on VCare for each incident/accident with immediate action noted, relative notification and any follow-up action required.</p> <p>A review of 15 incident/accident reports including witnessed and unwitnessed falls and skin tears for June and July 2021 were reviewed and identified that all were fully completed and included follow-up by a registered nurse. Neurological observations were completed for unwitnessed falls and where there was an obvious knock to the head. The unit coordinators and managers review adverse events as part of the weekly management meeting.</p> <p>The village manager and clinical manager were able to identify situations that would be reported to statutory authorities. There have been section 31 notifications completed for four non facility acquired pressure injuries.</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 (HR) policies including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (one clinical manager, one hospital unit coordinator, two registered nurses (RN) four caregivers (one from rest home, dementia, serviced apartments, and hospital), one housekeeper, one chef and one diversional therapist) contained all the required employment documents including job descriptions and completed orientations specific to their role. A three-month and six-month post-employment assessment is completed and annually thereafter.</p> <p>A general orientation programme for all new staff is completed on site at induction days. The induction/ orientation day covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers interviewed could describe the orientation process and felt staff were adequately orientated to their role.</p> <p>There is an implemented annual education plan that covers the mandatory training requirements and many topical debriefs/toolbox sessions at handovers. To date, the service has completed all compulsory training sessions, and staff have completed relevant competencies including (but not limited to); infection control, fire, medications, caregiver comprehension, moving and handling, and wound care. Staff complete education through face-to-face sessions and using the online education platform. As spreadsheet is maintained of sessions staff have completed, which also provides a notification of staff have completed and are overdue. All staff are first aid trained.</p> <p>There are 10 registered nurses including the four-unit coordinators. Three of the unit coordinators, two registered nurses and the clinical manager are competent in interRAI.</p> <p>There are 12 caregivers employed in the dementia care unit, one caregiver has completed their dementia unit standards with nine (employed less than one year) are progressing through the standards. One caregiver has completed a level 7 diploma of health sciences.</p> <p>Caregivers are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. Currently there are two staff who have completed level 3 NZQA, and three staff have completed level 4.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</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 and clinical manager/RN work Monday – Friday. The unit coordinator (RN) in the rest home special care (dementia) and serviced apartments (EN) works from Sunday to Thursday. The hospital coordinator (RN) works across Tuesday to Saturday.</p> <p>The RN in the hospital provides support to the rest home special care unit and serviced apartments as required</p>

experienced service providers.		<p>on the afternoon and night shifts.</p> <p>Rest home unit (with 23 rest home residents on the day of audit) has a unit coordinator or RN seven days (morning shifts), who is supported by three caregivers on the morning shift; 1x 7am to 3.30pm, 1x 7am to 3pm and 1x 7am to 1pm.</p> <p>The afternoon shift has three caregivers (including one senior caregiver with a medication competency); 2x 3pm to 11pm, and 1x 4pm to 9pm. Nightshift is covered by two caregivers; 1x 10.45pm to 7.15am and 1x 11pm to 7am</p> <p>Serviced apartments with one rest home resident on the day of audit: There is a senior caregiver who covers the serviced apartment coordinator days off. There are two caregivers on the morning from 7am to 1pm, and one caregiver on the afternoon shift from 4pm to 9pm. The night shift is covered by caregivers/RN in the hospital.</p> <p>Special care (dementia) unit with 12 residents on the day: A RN covers the unit coordinator days off. There are three caregivers on the morning shift; 1x 7am to 3.30pm, 1x 7am to 1.30pm and 1x 9am to 1pm. There are two caregivers on the afternoon shift: 1x 3pm to 9pm, and 1x 3pm to 11pm. There is one caregiver on the night shift.</p> <p>Hospital unit with 24 hospital level residents on the day of audit: In addition to the unit coordinator there are two RNs on morning and afternoon shifts and one RN on night shift. There are five caregivers on the morning shift; 2x 7am to 3.30pm, 1x 7am to 3pm and 2x 7am to 1pm. The afternoon shift has three caregivers: 2x 3pm to 11pm and 1x 3pm to 9. There are two caregivers from 11pm to 7am.</p> <p>Each unit has designated activities coordinator(s) and housekeeping staff. Residents and family members interviewed reported 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 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>
Standard 1.3.1: Entry To Services	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</p>

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		<p>interviewed stated they were well informed upon admission. The service has an information pack available for residents/families/whānau at entry including specific information on dementia level of care and the safe environment.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<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. Transfer notes and discharge information was available in the hard copy resident records of those with previous hospital admissions. The facility uses the 'yellow envelope' system</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. Any errors are fed back to the pharmacy. There were two rest home level residents self-medicating (inhalers and topical creams) 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. Sixteen medication charts were reviewed (six hospital, six rest home and four dementia care). All medication charts had photographs and allergies documented. Medication charts had been reviewed at least three-monthly by the GP (except for respite care residents and new admissions). 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>	FA	<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 is supported by one full time chef and two part time chefs. There are four kitchen hands and two cook assistants who work on a roster. There are also two part time bakers and baristas. The bakers</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>also supply the cafe. 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. Other dietary needs such as diabetic, gluten or dairy free are supplied as required. The seasonal menu has been designed in consultation with the dietitian at an organisational level. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes including weight loss. Dislikes are accommodated. Pure foods are used for pureed meals and as a base for soups and other suitable foods. Lip plates are available to encourage resident's independence with meals. Meals are delivered by scan boxes to the units where the meals are served by the caregivers. 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 were ample snacks, fluids and foods available in all the units. Each unit has a functioning satellite kitchen from where the breakfast is served. 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 monthly survey results for food services are positive.</p> <p>The food control plan was verified 9 December 2020.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs,</p>	<p>FA</p>	<p>In the files reviewed, an initial assessment and relevant risk assessment tools had been completed on admission for all residents including the respite care resident. 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</p>

support requirements, and preferences are gathered and recorded in a timely manner.		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.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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 eight 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 two 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, dietitian and mental health care team for older people. This was integrated into the electronic myRyman individualised record.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	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 23 wounds. There were skin tears, a laceration, leg ulcers and one surgical wound. There are currently three facility acquired pressure injuries – two stage 1 and one stage 2. All wounds/pressure injuries are linked to the care plans. Photos have been taken where relevant. Each floor has a wound champion. Ryman wound champions are able to contact the Ryman wound nurse specialist as required. Referrals are made as necessary to the dietitian and wound nurse specialist. The service has adequate wound products and pressure relieving equipment 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</p>

		<p>against clinical/care interventions for identified concerns or problems. Monitoring forms reviewed included (but not limited to) blood pressure, weights, blood sugar levels, pain, behaviour, repositioning charts, bowel records, food and fluids, intentional rounding, restraint and neurological observations. Intentional rounding is determined by the residents' need including toileting, whereabouts of residents or falls risk.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an activity team of two diversional therapists (DT) and two activities coordinators. There is an activity team member for each area and weekends are covered by staff. The Ryman Engage programme runs from Monday to Sunday. In the dementia unit the more flexible care companion model is utilised in the mornings. This allows more one on one activity with caregivers and activity team members working with residents on whatever they would like to do. Often this involves residents participating in activities they would have done at home, such as folding laundry, setting tables and baking. On the day of audit one resident was making egg sandwiches. In the afternoons it reverts to the Engage programme. The rest home residents in the serviced apartments can choose to attend the rest home or serviced apartment programme.</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, movies, indoor bowls, music and happy hour. There are events for ladies such as high teas, baking and pampering. There is a men's club. There is entertainment every Happy Hour. One village resident comes in and plays the piano and others assist with craft activities.</p> <p>There are weekly van outings for all areas. One van has wheelchair access. Pet therapy is fortnightly. There is an interdenominational church service weekly, and Catholics have weekly communion. Themed events and festive occasions are celebrated. The current theme is the Olympics with residents participating in varied events.</p> <p>Residents are encouraged to maintain community links. One of the rest home residents attends a gardening club and others like to be taken out shopping and for coffees. There are also visits from pre-schools and schools.</p> <p>Resident life experiences and an activity assessment are 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.</p> <p>Residents/relatives can feedback on the programme through the resident and relative meetings and surveys. The residents/relatives interviewed were satisfied with the activity programme. Activities were observed in each of the units with good resident attendance and participation.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans of long-term residents had been evaluated at three weeks prior to the development of the long-term care plan. Two files of residents who had been at the service six months identified that long-term care plans had been evaluated by registered nurses. Five of seven long-term resident care plans were not due for a six-monthly evaluation. The respite care resident was not required to have a care plan 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. 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 person's service, mental health services, 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</p>	FA	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Relevant staff have completed chemical safety training. Gloves, aprons, and goggles are available for all care staff and laundry/housekeeping staff and available in sluice rooms and laundry/housekeeping areas. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing while carrying out their duties. Chemicals are labelled correctly and stored safely throughout the facility. Safety data sheets and product information is available. The chemical provider monitors the effectiveness of chemicals and provides chemical safety training.</p>

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 a certificate for public use current till 7 October 2021. A building warrant of fitness will not be issued till construction has been completed. The care centre is across three levels: the dementia care unit on level 2, rest home unit on level 3, hospital unit on level 4. The serviced apartments are across all five levels. There are lifts between floors. A keypad code is required to utilise the dementia unit lift.</p> <p>The lead maintenance person and the support maintenance person both work full-time. 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 communal areas. The ensembles are spacious and safely accessible with the use of a hoist as demonstrated on the day of audit. There is a call bell at the head of each bed space.</p> <p>There is separate gardening and grounds team. Residents are able to access outdoor areas safely or with supervision.</p> <p>There is secure entry/exit to the two dementia 20-bed units. Currently only one unit is occupied as there are only twelve residents. Each unit has access to safe balcony areas with, planters, seating and shade. Each unit also has access to safe courtyard areas with raised gardens, seating and shade.</p> <p>Care staff interviewed state they have sufficient equipment to safely deliver the care 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</p>	FA	<p>All resident rooms (including the serviced apartments) have full toilet/shower ensembles. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Toilets in the dementia unit have signs and pictures as well as words. Toilet seats are a different colour in the dementia unit. Non-slip flooring and handrails are in place. Care staff interviewed confirmed they maintain the resident's privacy when undertaking personal cares.</p>

attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single with ensuites. All serviced apartments have a lounge, ensuite and separate bedroom. All bedrooms and ensuites across the rest home/hospital and dementia units are spacious for the safe use and manoeuvring of mobility aids. In the dementia unit doors to resident's rooms are painted different colours. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The hospital and rest home units have a large open-plan dining area with kitchenette and open plan lounge area. Seating is arranged to allow large group and small group activities to occur. Both units have a family room and quiet lounge. All serviced apartments also have their own spacious lounge and kitchenette as well as communal dining areas. The village centre is on the ground floor with communal areas available to care centre residents including the hairdresser room, beauty room, reflection room, library, movie theatre, gym and 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 courtyards 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 currently a laundry coordinator and one laundry assistant who work fulltime daily. Staff and shifts will increase as resident numbers grow. There are large commercial washing machines, sluice machine, delicate machine and dryers. The clean side has space for folding washing, ironing and a labelling machine. There is minimal unlabelled/unclaimed clothing. There is a large linen storeroom.</p> <p>The service has a secure area for the storage of cleaning trolleys and chemicals. There is a team of cleaners who cover seven days a week, five hours a day. Cleaner's trolleys were well equipped. A chemical dispensing</p>

		<p>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 in place to guide staff in managing emergencies and disasters. Emergency management and fire evacuations drills are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The village has an approved fire evacuation plan dated September 2020. Fire drills occur six-monthly in April and October. The village manager has engaged with the local fire stations who perform regular fire drills and practices around the facility to ensure their familiarity with the facility in the event of a fire or emergency. There is a designated storage room which holds emergency supplies which is centrally located and can be accessed in the event of any emergency situation. There is a food and water supply to last for at least three days. The service has a generator which is serviced at least six-monthly.</p> <p>There is an effective call bell system in all bedrooms, ensuites and communal areas. The call bells and door alarms are linked to pagers carried by staff. Calls light up on the main call panel in the nurse's station. The indicator lights on the outside of the resident room indicates whether the resident requires help, or the nurse is in attendance for privacy reasons.</p> <p>There is secure entry and exit to the dementia care unit. The call points in the dementia unit are specifically designed to disguise the emergency button. There are sensors within the room which alert staff to whether the resident is mobile in the room or is in the bathroom.</p> <p>The facility is secure after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There are heat pumps in communal areas and residents' rooms have electric panel heaters. There are external windows in resident rooms and communal areas with plenty of natural sunlight. The facility is a smoke free environment.</p>

comfortable temperature.		
<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 infection prevention and control programme is linked into the quality management system. The infection prevention and control committee meet bi-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. An appointed registered nurse (clinical manager) responsible for infection prevention and control at the facility. She has been in the role since October 2020.</p> <p>Visitors are reminded not to visit if they are feeling unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control updates and has attended external infection control officer training in March 2021. The infection control team is made up of the four-unit coordinators and the clinical manager. Resident care plans reviewed included comprehensive documentation for any known infections.</p> <p>External resources and support are available when required. Ryman is a member of Bug control. 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. All visitors are required to complete an electronic wellness questionnaire on arrival to the facility and contact tracing measures are in place.</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</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, procedures and the pandemic plan have been updated to include Covid19.</p>

organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection prevention and control coordinator is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care and also during relative/resident meetings. Staff have completed training around donning and doffing personal protective equipment (PPE), antimicrobials, use and storage of hand sanitizers, and continence. Training and notices around infections are communicated through the ChattR platform.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator who is a registered nurse.</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 bi-monthly infection prevention and control (IPC) meetings. All meetings held at William Sanders include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation. There is an electronic programme that generates graphs of data which is used to report data at meetings.</p> <p>There have been no outbreaks since William Sanders opened in October 2020.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were no residents using restraints or enablers on the day of the audit. Restraint is actively minimised. Staff interviewed were knowledgeable around restraint and enabler use, and associated processes.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

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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.

No data to display

End of the report.