

Jane Winstone Retirement Village Limited - Jane Winstone Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Jane Winstone Retirement Village Limited
Premises audited:	Jane Winstone 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: 27 October 2021 End date: 27 October 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	69



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

General overview of the audit

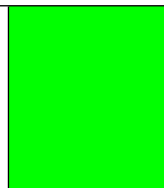
Jane Winstone is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital, and dementia level care for up to 89 residents. On the day of the audit there were 69 residents. The village manager (non-clinical) has been in the role since April 2021 and is supported by a resident services manager/registered nurse (RN) and a clinical manager/RN. The management team is supported by a regional manager and support staff at head office. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff, and a nurse practitioner. Residents and relatives spoke very positively about the services that they are receiving.

The service has addressed the two previous audit shortfalls around care interventions and their implementation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

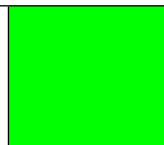


Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented, and complaints and concerns are actively managed and well-documented.

Organisational management

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



Standards applicable to this service fully attained.

Services are planned, coordinated, and appropriate to the needs of the residents. A village manager, resident services 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 being implemented. Corrective actions are implemented and evaluated where quality improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place, which includes in-service education, online learning, and competency assessments.

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.

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.

The registered nurses' complete assessments, care plans and evaluations within the required timeframe. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner or nurse practitioner completes admission visits and reviews the residents at least three-monthly.

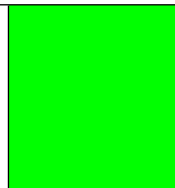
The activity team provides an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The Engage programme meets the abilities and recreational needs of the groups of residents. The programme is varied and involves community visitors. There were individualised 24-hour activity plans for residents in the dementia care unit.

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

The project delicious menu is designed by a dietitian at an organisational level. All baking and meals are cooked on site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24-hours in the dementia care 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 warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely. Residents can freely access communal areas using mobility aids. Outdoor areas and the internal courtyards are safe and accessible for the residents.

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.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents using restraint and one resident using an enabler at the time of the audit. A restraint register is maintained. Staff receive training around restraint minimisation and the management of challenging behaviour.

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 team hold integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed for analysis and benchmarking. A six-monthly comparative

summary is completed. The service has had two outbreaks since the last audit. There are robust Covid-19 risk prevention strategies implemented.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with four residents (one hospital, three rest home including one in a serviced apartment) and families, demonstrated their understanding of the complaints process. Ten staff interviews (four caregivers [one dementia, one serviced apartment, two hospital/rest home], two registered nurses [RNs], one chef, two diversional therapists, one maintenance staff) confirmed their understanding of the process around reporting complaints.</p> <p>There is a complaint register. Six complaints were lodged in 2020 and six have been lodged in 2021 (year-to-date). One complaint received via the Health and Disability Commissioner (HDC) on 22 June 2020 was closed on 11 June 2021. Corrective actions implemented as a result of the HDC complaint included the following: additional staff training in relation to the transfer process to a higher level of care (e.g., DHB), management of wounds, identification and treatment of pressure injuries, identification, and management of leg ulcers and highly exuding wounds, and refresher on resuscitation policies. Staff have been reminded to escalate care concerns to the RN team with urgency, and the management of complex wounds will include input from the DHB wound care specialist. At head office, the fluid charting policy has been reviewed and updated.</p> <p>All complaints reviewed had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned. Complaints were documented as resolved.</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.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Six family members interviewed (one rest home, two dementia, three hospital) confirmed they are notified following an accident/incident and/or a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters are available. Family is used in the first instance.</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>Jane Winstone is a Ryman healthcare retirement village located in Whanganui. Jane Winstone provides rest home, hospital (including medical services) and dementia level care for up to 89 residents including 20 serviced apartments certified to be able to provide rest home level care. The care centre includes 39 dual-purpose (rest home/hospital) beds, 10 hospital-only level beds, and 20 dementia level beds. During the audit, there were 29 rest home level residents, which included one resident in a serviced apartment; 20 hospital level residents including one on a long-term service - chronic health conditions (LTS-CHC) contract; and 20 dementia level residents including one on a DHB funded intermediate care contract. All remaining residents were on the age-related aged care contract.</p> <p>There is a Ryman strategic and quality plan and a TeamRyman quality programme. 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 non-clinical village manager has been in her role since April 2021 and has previous senior management experience. She was unavailable during this unannounced surveillance audit. The village manager is supported by a clinical manager (RN) who has been in the role for over four years, and a resident services manager/RN who has been in the role for five weeks. The resident services manager is the second in charge. Previous to this recent appointment, he was a unit coordinator for over five years at another Ryman facility. Two-unit coordinators/RNs (one serviced apartment and one dementia) support the clinical manager.</p> <p>The village manager, clinical manager and resident services manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The Ryman quality management system is fully implemented. Quality data and outcomes are reported across the various meetings, including the full facility, RN/clinical and TeamRyman (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 corrective actions. 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 staffroom.</p> <p>Relative and resident surveys are completed annually although are slightly behind schedule due to the recent Covid lockdown. Results have been collated with annual comparisons for each service. The most recent relative survey (August 2020) reflected an average satisfaction score of 4.21 out of a possible score of 5 and the resident average satisfaction score (February 2021) was 4.11. Areas actioned for improvements were around care and activities (relative survey) and food and activities (resident survey).</p> <p>Monthly clinical indicator data is collated across the care centre (including any rest home residents in the serviced apartments). There is evidence of trending of clinical data and development of corrective action plans when targets are not met. A range of falls prevention strategies are in place. All falls' data is trended based around the time of the fall and location of the fall. Interventions include intentional rounding, encouraging residents to participate in the lounges where they can be observed more closely, and regular toileting regimes. Challenging behaviours are also analysed with distraction, reassurance and spending one on one time with the residents. The rate of challenging behaviours has increased due to the number of new admissions since the previous audit.</p> <p>Health and safety policies are implemented and monitored as evidenced in the monthly health and safety meetings. The service documents and 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 (e.g., food safety audits, emergency call bell audits, environmental audits, fire safety audits, waste management audits). 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,</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident, with immediate action noted and any follow-up action required.</p> <p>A review of fifteen incident/accident reports (witnessed and unwitnessed falls, skin tears, challenging behaviours,</p>

<p>unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>pressure injury) identified that all were fully completed and include timely follow-up by a registered nurse. Unwitnessed falls include neurological observations as per policy. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.</p> <p>The resident services manager interviewed was able to identify significant events that would be reported to statutory authorities, which has included section 31 reports for the change in village manager and for a pressure injury. Two infectious outbreaks (August 2021 and October 2021) were reported to the public health authorities and the DHB.</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>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files reviewed; (one chef, one gardener, one RN, one administrator, one activities and lifestyle coordinator, one housekeeper and one caregiver) included a signed contract, job description, police checks, induction, application form and reference checks. Staff files reviewed included probationary and annual performance appraisals.</p> <p>A register of registered nurse's practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice.</p> <p>There is an implemented annual education plan that includes both in-service and online education. Each month the service is informed, via TeamRyman regarding what education is to be provided as well as any resources needed. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Seven of twelve registered nurses have completed interRAI training. Staff competencies are completed as relevant to the role. Registered nurses participate in two monthly RN/EN journal club which provides clinical updates and guidance. Coordinators are supported to attend the Ryman leadership training.</p> <p>There are 15 staff who work in the dementia unit and all 15 have completed the required dementia unit standards. In total for the facility, five caregivers have achieved a level two qualification, twenty-one have achieved a level three qualification and six have achieved a level four qualification.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The service staffing includes;</p> <p>A village manager and resident services manager who work Monday to Friday and a clinical manager who works Sunday to Thursday. The unit coordinator (RN) for the dementia unit and unit coordinator (RN) for the serviced apartments are rostered Tuesday to Saturday.</p> <p>In addition to the above, the dementia unit (20 residents) staffing included and RN on the days that the unit coordinator (UC) is unavailable (Sunday/Monday). Two caregivers are rostered on the AM shift (one long [eight hour] shift and one short shift to 1330). Two (long shift) caregivers cover the PM shifts and nights. A lounge assistant is rostered from 1600 – 2000.</p> <p>The rest home/hospital wing (20 hospital level and 28 rest home level residents) staff includes a staff RN on each shift. A second RN has just been employed and will begin working from 0900 – 1300 Tuesday – Saturday. Three long shift and four short shift caregivers are rostered on the AM shift, two long shift and four short shift caregivers are rostered on the PM shift and two long shift caregivers are rostered on the night shift. A fluid assistant is rostered from 0930 – 1300, seven days a week.</p> <p>The serviced apartments (one rest home level resident) is staffed with one long and one short shift caregiver on the AM shift, and two short shift caregivers on the PM shift. The PM shift hands over to a designated caregiver at 2130 and is attended to by care centre staff through the night.</p> <p>On the days of audit, staff on duty were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that complies with relevant medication guidelines and legislation. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver competencies. Regular and 'as required' medications are delivered in blister packs which are checked by an RN against the electronic medication charts. Any errors are fed back to pharmacy. Medications are stored safely in the care centre and the special care unit.</p> <p>Caregivers and RNs interviewed were able to describe their role in regard to medicine administration. A caregiver observed on a medication round (special care unit) followed correct procedures. Education around safe medication administration has been provided. Medication fridges were monitored weekly, and temperatures were within acceptable limits. The service has commenced medication room temperatures which evidence they do not exceed 25 degrees. All eye drops, ointments and sprays were dated on opening. All medications were prescribed for the residents and no bulk supply order was held on site. There were two self-medicating residents; one rest home (eye drops) and one hospital level (inhaler) with self-medication competencies signed by the GP or NP. Medication was</p>

		<p>stored safely in the residents' rooms; residents sign a self-medication indemnity form. Staff record that they have checked medication has been administered.</p> <p>Ten electronic medication charts were reviewed and evidenced that all medication documentation has been completed appropriately including review dates, charting and administration signing. The effectiveness of 'as required' medications is recorded in progress notes and in the electronic medication system. All medication charts had photo identification and the allergy status recorded. Nutritional supplements are charted and administered and sign for on the electronic chart. There are no standing orders or nurse-initiated medication orders.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking are prepared and cooked on site. The qualified lead chef has been in the role for 12 months and is supported by a second chef, morning, and afternoon kitchen assistants. Staff have been trained in food safety and chemical safety. Project-delicious is continuing with four weekly seasonal menu which is reviewed regularly by a dietitian at organisational level. The menu offers three choices for the midday main meal and two meal options for the evening meal as well as a vegetarian and gluten free option. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. Nutritional profiles reviewed evidenced all profiles have been assessed within the last six months and are a current reflection of their needs. Special diets such as pureed/soft diets are provided. Resident dislikes and dietary preferences were known and accommodated.</p> <p>Nutritious snacks are available 24 hours in the special care unit. Meals are delivered in hot boxes to the special care unit dining room and served from bain maries in the unit kitchenette and serviced apartments. This audit was conducted under Covid-19 level two and residents were maintaining social distancing in the dining rooms, some residents were enjoying meals in their rooms (plated service) and in the lounges to support Ryman Covid-19 risk prevention policy. There are special utensils available for residents that require this. A fluid assistant works in the care facility in the mornings to support the resident's hydration needs. There is a weekly fluid menu available to assist and encourage fluid intake.</p> <p>There is a current food control plan which expires 9 May 2022. Freezer/chiller temperatures, end-cooked temperatures, calibration of probes, cooling and inward chilled goods temperatures are taken and recorded daily. All foods in the pantry were date labelled. All perishable foods in refrigerators were date labelled. A cleaning schedule is maintained including high cleans recently completed by an external contractor. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, surveys, and direct contact with the chef. Residents interviewed commented there had been an improvement on the meals provided.</p>
<p>Standard 1.3.5: Planning</p>	FA	<p>MyRyman care plans reviewed were resident-centred and included medical information, allied health instructions, activities of daily living including general likes and dislikes, categories of care with support needs and interventions</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>to meet the resident goals. InterRAI assessments trigger areas where support needs are identified. These triggers and general risk assessments are used to develop the long-term care plan. Example of files reviewed include support needs for pressure injury prevention including skin and nutrition management, catheter, and continence management, falls prevention and weight managements strategies. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. Care plans included the involvement of allied health professionals in the care of residents. The shortfall identified at the previous audit around addressing all care needs has been addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, a registered nurse initiates a review and if required, a GP or nurse practitioner will visit and review the residents. Interventions required were documented in the resident's care plan. Residents interviewed stated their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place (on the electronic database) for 15 wounds (ulcers, skin tears, lesions and two pressure injuries). Scheduled change of dressings and evaluations had been completed. There was one resident with a facility acquired unstageable pressure injury on the day of audit and one resident with a stage two pressure injury (facility acquired). Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse as required and this was evident in the file of the resident with an unstageable pressure injury. The GP or NP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans.</p> <p>Continence products are available and resident files included 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 forms are in place to monitor a resident's progress against interventions implemented for changes to health. Monitoring charts included (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, restraint monitoring, repositioning, pain monitoring, blood sugar levels and behaviour charts. Neurological observations had been completed as per protocol where required for unwitnessed falls with or without a suspected head injury. The shortfall identified at the previous audit related to the completion of monitoring charts has been addressed.</p> <p>Progress notes document changes in health and significant events.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>There is a team of activities staff (two diversional therapists, an activity assistant, van driver) who coordinate and implement the Engage programme across the care centre and the dementia care unit. The Engage programme has</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, walking groups, sensational senses, make and create, reminiscing, themes events and celebrations including upcoming Melbourne Cup and Halloween, baking and cooking, games, entertainment, outings, and drives.</p> <p>Activities are provided Monday to Sunday until 6 pm in the special care unit and Tuesday to Fridays from 8.30 am-4.30 pm and Saturday, Sunday, and Monday till 3 pm in the care centre. An evening lounge carer (4 pm-8 pm) in the special care unit also offers a range of activities, de-escalation, and diversion if required. Caregivers in the dementia care unit incorporate activities and one-on-one time with residents as part of their role. Two afternoons a week is allocated to spend one-on-one time with care centre residents who choose to stay in their rooms and not participate in group activities. There are regular outings/drives for all residents as appropriate (weekly for dementia residents and twice a week for residents in the care centre), weekly entertainment and involvement in community events. On site church services are held in the facility chapel. Community visitors include volunteers, village residents, entertainers, and canine pet therapy.</p> <p>There is a salon on site, a shop for general items and whānau room for private conversations and meetings. The DTs interviewed confirmed that outside of Covid-19 alert levels residents across the service will attend activities once a week together. Communal areas in the special care unit provided with safe, adequate, appropriate, and accessible areas to meet residents' relaxation and activity needs.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. Behaviour management plans for dementia care residents included de-escalation and redirection using individual one-on-one time and activities. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. There is a bimonthly resident meeting for the care facility's residents and a six-monthly relative meeting with the relatives from the special care unit. Residents and relatives interviewed commented positively on the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans reviewed had been evaluated by registered nurses for long-term residents who had been at the service six months. One dementia intermediate care resident did not have a long-term care plan in place yet. Written evaluations for long-term residents describe the resident's progress against the resident's identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, and activities staff. Input is sought from caregivers and other allied health professionals involved in the care of the resident. The GP or NP reviews the residents at least three-monthly. Family is invited to the multidisciplinary review and notified of the outcome/changes if unable to attend. There is documented evidence of family involvement in the care plans. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP or NP visits.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 17 March 2022. The facility employs a maintenance staff member and a gardener who report to the resident services manager. Requests for repairs are logged into an internal maintenance book which is checked frequently throughout the day and signed off as repairs are completed. There is a planned maintenance schedule which includes internal and external building maintenance and equipment checks. Electrical testing is completed annually. Hot water temperatures in resident areas are monitored six monthly and as required as part of the environmental audits. Temperature recordings reflect tempering valve adjustments by a plumber if resident tap or shower temperatures exceed 45 degrees Celsius. Contractors are available 24 hours for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the gardens and grounds with seating and shade provided.</p> <p>The dementia care unit is located on the ground floor with doors that open out onto secure gardens with walking pathways. Seating and shade are provided.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>	<p>FA</p>	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator who is a registered nurse. The registered nurse reports to the clinical manager.</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 Jane Winstone include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation.</p> <p>There have been two respiratory outbreaks at the facility since the last audit. All were reported to Public Health, contained to one unit, and managed appropriately and effectively.</p> <p>Ryman operates under a decision matrix for managing community Covid-19 risk response per phase or risk level. Staff are required to be fully vaccinated, using N95 masks and were observed practising good hand hygiene. Relatives, visitors, and contractors are required to complete a Covid-19 symptom, temperature monitoring and vaccination declaration on entry and required to use the N95 masks provided. Relatives that have not yet been fully vaccinated are required to make appointments and visits are restricted to the whānau room only. Relatives interviewed confirmed they are fully informed of the visiting requirements and residents receive continuous advice around hand washing and preventative measures. Staff interviewed confirmed they have sufficient supplies of PPE</p>

		<p>stock available.</p> <p>There are clear guidelines available for cleaning between equipment use, touch screen devices for sign in, and tablets for accessing resident records and medication charts and reusable eyewear.</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 a restraint during the audit and one hospital level resident was using a safety belt in their wheelchair as an enabler. Voluntary consent and an assessment process had been completed. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</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.

No data to display

End of the report.