# Julia Wallace Retirement Village Limited - Julia Wallace Retirement Village

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

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 Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Julia Wallace Retirement Village Limited

**Premises audited:** Julia Wallace 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: 7 March 2024 End date: 8 March 2024

**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:** 86

# 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 sections contained within the Ngā paerewa Health and disability services standard:

* ō tātou motika **│** our rights
* hunga mahi me te hanganga │ workforce and structure
* ngā huarahi ki te oranga │ pathways to wellbeing
* te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
* te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
* here taratahi │ restraint and seclusion.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded |
|  | No short falls | Subsections 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 subsections applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some subsections 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 subsections applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Ryman Julia Wallace provides rest home, hospital, and dementia-level care for up to 104 residents, including the care centre and the serviced apartments. On the day of the audit, there were 86 residents at the care centre including four residents in the service apartments.

The service is managed by the village manager, clinical manager, resident services manager, and unit coordinators. They are supported by the regional operations manager and the Ryman Board. The residents and relatives interviewed spoke positively about the care and support provided. Consumer survey results shows high satisfaction with the services provided, communication, environment and grounds of the facility.

This surveillance audit was conducted against a sub-section of Ngā Paerewa Health and Disability Services Standard 2021 and funding agreements with Health New Zealand Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral. The audit processes included observations; a review of organisational documents and records, including staff records and the files of residents; interviews with residents and family/whānau; and interviews with staff, management, and the nurse practitioner.

The audit finding from the previous audit around health and safety is addressed.

This audit identified an improvement required around an aspect of medication management.

## Ō tātou motika │ Our rights

|  |  |  |
| --- | --- | --- |
| Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people’s rights, facilitates informed choice, minimises harm,  and upholds cultural and individual values and beliefs. |  | Subsections applicable to this service fully attained. |

Ryman Julia Wallace has a Māori and Pacific people’s health policy and other relevant documents to fulfil their obligations and responsibilities under Te Tiriti o Waitangi. Individualized care is delivered with a specific emphasis on acknowledging and respecting the beliefs, values, and cultural backgrounds of each person. The Pacific People’s policy includes the Pacific health plan.

Training on abuse and neglect is provided to staff. It was evidenced that the Code of Health and Disability Services Consumers' Rights has been effectively implemented. Observations and evaluations during the audit underscore a commitment to upholding the rights and dignity of all residents. Informed consent processes are implemented. The complaints management process is implemented.

## Hunga mahi me te hanganga │ Workforce and structure

|  |  |  |
| --- | --- | --- |
| Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce. |  | Subsections applicable to this service fully attained. |

Ryman Julia Wallace is implementing their quality and risk management programme. There is a comprehensive health and safety system in place with identified health and safety goals.

There is a clinical governance structure in place with terms of reference that is appropriate to the size and complexity of the service provision. The Board monitors performance of the company, with reports written quarterly. The senior leadership and wider leadership team meet regularly to discuss key performance indicators, including quality and risk.

A significant number of staff maintain current first aid certificates so that there is always a first aider on site. Staff employed are provided with orientation and ongoing support through training. There is an extensive training programme within the service with comprehensive records retained and a high rate of participation. Staff coverage is maintained for all shifts.

## Ngā huarahi ki te oranga │ Pathways to wellbeing

|  |  |  |
| --- | --- | --- |
| Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs. |  | Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents are assessed before entry to the service to confirm their level of care. The nursing team is responsible for the assessment, development, and evaluation of care plans. Care plans were individualised and based on the residents’ assessed needs. Interventions were appropriate and evaluated promptly.

There is a medicine management system in place. The organisation uses an electronic system for prescribing and administration of medications. The general practitioner and nurse practitioner are responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents’ specific dietary likes and dislikes. Residents’ nutritional requirements are met. Cultural needs are able to be met. Nutritional snacks are available for residents 24 hours a day. A current food control plan is in place.

Residents are referred or transferred to other health services as required.

## Te aro ki te tangata me te taiao haumaru │ Person-centred and safe environment

|  |  |  |
| --- | --- | --- |
| Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities. |  | Subsections applicable to this service fully attained. |

The building has a current warrant of fitness. A maintenance plan is adhered to, and all equipment is tagged, tested, and calibrated as scheduled.

## Te kaupare pokenga me te kaitiakitanga patu huakita │Infection prevention and antimicrobial stewardship

|  |  |  |
| --- | --- | --- |
| Includes five subsections that support an outcome where Health and disability service providers’ infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance. |  | Subsections applicable to this service fully attained. |

The infection prevention and control programme is appropriate for the size and complexity of the service. The programme is linked to the quality improvement programme and approved by the governing body. Staff completed training around infection prevention and control.

The infection surveillance programme is implemented. Surveillance of all infections is reported on a monthly infection summary and action plans are implemented. This data is monitored and analysed for trends, monthly, six monthly and annually.

## Here taratahi │ Restraint and seclusion

|  |  |  |
| --- | --- | --- |
| Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people’s dignity and mana are maintained. |  | Subsections applicable to this service fully attained. |

The service aims for a restraint-free environment. This is supported by the governing body and policies and procedures. A restraint was in use at the time of audit. Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques, and alternative interventions.

## Summary of attainment

The following table summarises the number of subsections 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)** |
| **Subsection** | 0 | 17 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 48 | 0 | 0 | 1 | 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)** |
| **Subsection** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Subsection with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Subsection 1.1: Pae ora healthy futures  Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi. | FA | Ryman Julia Wallace has a Māori health policy, a Māori health plan, and a Māori engagement framework, which collectively outlines how the facility responds to the cultural needs of Māori residents, and how it fulfils its obligations and responsibilities under Te Tiriti o Waitangi.  The resident services manager confirmed that the service supports the Māori workforce. Iwi affiliations for staff are recorded in staff files as appropriate.  On the day of audit, there was a resident who identified as Māori. A review of the cultural aspect of the care plan showed that the care was provided equitably and based on Te Tiriti o Waitangi principles with recognition of mana motuhake.  Staff (three registered nurses, five caregivers, one cleaning staff, one kitchen manager, one diversional therapist, a maintenance staff) and management interviews (resident services manager, hospital unit coordinator, and regional operations manager) confirmed that the staff have completed cultural safety training and are proficient in discussing principles of Treaty of Waitangi and applications within their roles. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa  The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes. | FA | The service has a current Pacific People’s policy which includes the Pacific health plan. These documents guide staff on how Pacific people who engage with the service are supported. Currently, there are no Pasifika residents or staff members at the facility. Staff when interviewed, demonstrated an understanding of Pasifika culture, its relevance to their policies, and were knowledgeable about how to access community support for Pasifika individuals. |
| Subsection 1.3: My rights during service delivery  The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | FA | A welcome package is provided that contains details about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code), and there is an opportunity for residents and their families to discuss aspects of the Code during the admission process. Interviews with seven relatives (two from the hospital, two rest home and three from the dementia unit) and six residents (three from the rest home and three from the hospital) revealed that they received information at admission which included the Code. Posters in large print featuring the Code and information on advocacy are prominently displayed across the facility in both English and te reo Māori. Both residents and relatives are briefed on the extent of services provided and any financial responsibilities for services not covered under the scope, all of which are detailed in the service agreement.  Two monthly residents’ meetings allow for the opportunity for residents to express their preferences with respect to areas such as food, activities, and where they prefer to spend their time within the facility. If any issues are raised by residents during the meetings, then they are promptly addressed and followed up on. At the subsequent meeting, satisfaction with the resolution of these issues was confirmed with the residents. Māori cultural activities are part of the activities programme.  Staff interviewed were knowledgeable about the Code and reported that they supported residents to know and understand their rights. |
| Subsection 1.5: I am protected from abuse  The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse. | FA | Julia Wallace has implemented a comprehensive training program for all staff, focusing on sensitivity, ethics, and the importance of maintaining professional boundaries. This training is updated regularly to address emerging issues and reinforce the facility's zero-tolerance policy towards any form of abuse or discrimination. The effectiveness of this training is evident in the consistently positive feedback from resident and family satisfaction surveys, which highlight the respectful, compassionate care provided by the staff.  Moreover, two monthly resident meetings provide a platform for voicing concerns and suggestions directly to management. Resident meetings have been instrumental in promoting a culture of openness and mutual respect, further ensuring that the rights and dignity of all residents are upheld. These measures, alongside the policies and procedures already in place, demonstrate the facility's ongoing commitment to creating a safe, inclusive environment that respects the dignity and rights of all individuals in its care.  Systems are established to oversee the personal finances of residents. Residents have the option to buy items from the facility's shop or have additional services and external purchases made on their behalf. The administrative staff maintains records of these transactions. Interviews with residents and families indicate that resident’s financial and property rights are upheld, and professional boundaries are consistently observed. |
| Subsection 1.7: I am informed and able to make choices  The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control. | FA | There are policies around informed consent. Resident files reviewed included completed general consent forms and consents for influenza and COVID-19 vaccinations. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms of residents in the dementia unit were appropriately signed by the activated enduring power of attorney (EPOA). All documentation regarding enduring powers of attorney and activation is on file. |
| Subsection 1.8: I have the right to complain  The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement. | FA | The complaints procedure is an equitable process that is provided to all residents and relatives on entry to the service. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Julia Wallace has an up-to-date complaint register. Concerns and complaints are discussed at relevant meetings.  There have been four complaints made in 2023 and 2024 year to date. Two complaints were care related, one with food services and one with living space and personal items. Review of the complaint register showed that all complaints were managed in accordance with the HDC Code. All concerns were addressed promptly and resolution was documented. Residents were informed of the outcome.  Residents, and families/whānau stated that they have a variety of avenues they can choose from to make a complaint or express a concern, including the two monthly resident meetings and six-monthly family/whānau meetings. Interviews with the resident services manager and clinical manager confirmed their understanding of the complaints process. Document review and staff interviews confirmed that the complaints process works equitably for Māori and support is available. There is an understanding that face to face meetings with whānau are preferred in resolving any issues for Māori. |
| Subsection 2.1: Governance  The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. | FA | Julia Wallace is a Ryman Healthcare retirement village located in Palmerston North. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care in their care centre for up to 104 residents including 20 serviced apartments that are certified to provide rest home level care. In the care centre, there are 84 beds. Sixty-three of these beds are dual-purpose (rest home/hospital) beds. There are 21 beds in the secure special care unit for dementia level of care.  At the time of the audit, occupancy was 86 including 28 residents requiring hospital level of care, 34 using rest home level care, 20 residents in the dementia care unit, and four residents receiving rest home level care in the serviced apartments. One resident requiring rest home care was under a transitional care contract and all remaining residents were on the age-related residential care (ARRC) contract.  Ryman Julia Wallace is managed by a village manager who is non-clinical and has been in the role for 18 months. The village manager was on leave on both days of audit.  “Good enough for mom or dad. We do it safely or not at all.” These are key business goals for Ryman Healthcare and are embedded in everything they do from the board level to the village. Policy, procedure and training resources ensure that these are embedded in all practices and day to day operations.  There is a clinical governance structure in place with terms of reference that is appropriate to the size and complexity of the service provision. As per the terms of reference of the clinical governance committee, they review and monitor audit results, complaints, consumer survey results, mandatory reporting requirements and clinical indicators for all villages including Ryman Julia Wallace. Reporting of risk is another key report communicated to the board by the senior leadership team. The board monitors performance of the company, with reports written quarterly. The senior leadership team for Ryman Julia Wallace and the wider leadership team meet regularly to discuss key performance indicators, including quality and risk.  The Māori health plan is developed in partnership with local iwi and community groups. This ensures that policy and procedure within the company and the governance body represents Te Tiriti partnership and equality. The Ryman Quality Auditor who has a Taha Māori focus liaises with other teams within the business to assist in identifying barriers for Māori, and to improve policy and processes so that they are equitable and inclusive. Reports are sent to the board and senior executive leadership team to address inequity as appropriate. A culture and equity resource, and a share point page are being developed. Feedback has been sought from team members and kaumatua. |
| Subsection 2.2: Quality and risk  The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers. | FA | Ryman Julia Wallace is implementing their quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Clinical indicator data is entered into the electronic resident management system and analysed at the head office, where the data is benchmarked within the organisation, and results are shared in staff meetings. A range of meetings are held monthly, including full facility meetings, health and safety, infection control, and registered nurse meetings. Discussion with staff and review of records demonstrated that all subsequent learnings from audits and accidents/incidents that occurred were reviewed through the head office in a meaningful way to identify trends and learnings that could be used to affect change or influence practice.  There are monthly Team Ryman (quality/management) meetings and weekly manager meetings. Discussions include (but are not limited to) quality data, health and safety, infection control/pandemic strategies, complaints received (if any), staffing, and education. Audit and inspection outcomes were reviewed, and required corrective action was followed up, showing service improvements.  Internal audits were completed as scheduled, and outcomes show a high level of compliance with the Ryman policies and procedures. Any areas that required improvements were followed up, and the audit was repeated, ensuring that the quality loop was closed.  Julia Wallace has village specific objectives that include enhanced resident and relative experience through communication, drive positive team culture and reduction in clinical indicators such as skin tears, skin infections, falls and pressure injuries. Progress towards achieving these goals is monitored monthly, six monthly and annually.  Residents and relatives surveys were undertaken annually. Results were analysed, and a summary report was shared with staff residents and relatives. Following this report, corrective actions were developed, and follow up implementations were completed. Survey results from residents indicated an average satisfaction rating of 3.92 out of 5, reflecting their overall experience. Notably, satisfaction with communication improved from the previous year. Surveys from relatives showed an average score of 4.03, with the highest ratings given to care services and the condition of the building and grounds. Staff surveys were undertaken annually, results were compared with the previous year, and corrective actions were developed collectively with staff in areas that they want to score better in. Staff satisfaction survey results were higher than the previous year.  There is a comprehensive health and safety system in place with identified health and safety goals. The health and safety committee meets monthly with a wide range of topics covered including work related risks, opportunities for improvements, and topics related to staff, residents and visitors’ wellbeing. The hazard registers detail the risk and how each risk is mitigated and controlled. These are reviewed annually and were up to date with risks currently in the service. Contractor’s sign into the village using an electronic sign in process and they are orientated to the facility prior undertaken their work. The contractor implicated in the incident has been removed from the list of approved contractors. During the audit, it was observed that contractors working on repairs and painting in the corridor leading to the service apartments were adhering to health and safety regulations, ensuring that no equipment was left unattended in a manner that could pose a risk. The previous audit identified a near miss event, which has since been resolved and the previous shortfall has been addressed.  All resident incidents and accidents are recorded on the electronic system. Ten accident/incident forms reviewed evidenced immediate action noted and any follow-up action(s) required. Incident and accident data is collated monthly and analysed. Results are discussed in the quality and staff meetings and at handovers. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse (RN).  Discussions with the clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been two Section 31 notifications completed to notify HealthCERT since the last audit. These were related to pressure injuries. Notification was sent appropriately of any infectious outbreaks.  The service is focused on achieving Māori health equity, identifies external and internal risks and opportunities, including potential inequities, and has developed a plan to respond to them. Residents services manager stated that the Ryman quality auditor who has a taha Māori focus, guides Ryman Julia Wallace in building partnerships within their community and assist them in facilitating this with their community and with kaumatua. |
| Subsection 2.3: Service management  The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services. | FA | Julia Wallace employs a total of 130 staff in various roles. Staffing rosters were sighted, and there are staff on duty to meet the resident's needs. The clinical manager is an experienced registered nurse with a current practising certificate who works full time including one day on weekend. There is support from four unit-coordinators (rest home, hospital, dementia and serviced apartments) who stagger across a seven day a week schedule/roster. The rest home unit coordinator position was vacant on the day of the audit, and this role was being supported by the clinical manager and an RN. The recruitment process for this position is currently underway.  The facility covers two floors with an elevator and stairs for access. There are twenty serviced apartments certified to provide rest home level of care that span two floors with four rest home level residents during the audit. The serviced apartment unit coordinator (RN) or a senior caregiver cover seven days a week and are supported by caregivers rostered onto the morning and afternoon shifts. The rest home caregivers cover the serviced apartments after 10 pm and through the night shift. Staff communicate via mobile telecommunications.  The rest home wing (28 residents) is located on the ground floor. Staffing includes a rest home coordinator/RN (Tues– Sat) and a senior caregiver on Sunday/Monday. Caregivers are rostered onto each shift with a dining assistant who support evening mealtimes. The hospital wing (34 residents including six rest home and 28 hospital level care), is on the ground floor, is staffed with a unit coordinator/RN (Sun - Thurs) and RNs and caregivers on each shift. There is a fluid assistance support staff on in the mornings and over lunch. The first level includes the secure dementia unit (20 residents). The dementia unit is staffed with a unit coordinator (RN) from Sun – Thursday and an RN on Friday and Saturday. Caregivers are rostered onto each shift. There are separate cleaning, laundry and admin staff rostered. Each area has an activities coordinator, (including three diversional therapists) and a physiotherapy assistant who supports the hospital wing.  In the evaluation of staffing adequacy within the service, positive feedback was consistently observed from the residents and families. Staff members expressed satisfaction with current staffing levels.  A significant number of staff maintain current first aid certificates so there is always a first aider on site. There is an extensive training programme within the service characterized by comprehensive records and a high rate of participation. This reflects a significant dedication to fostering staff development and enhancing competencies. The training programme included clinical trainings on different subjects, and training around the Code, infection control, restraint elimination, staff wellbeing, aging promotion and dementia related subjects, safe medication management, te reo Māori, tikanga Māori, Te Tiriti o Waitangi, infection prevention and control and outbreak management. Training also included residents wellbeing, promotion of health and managing valuables and cash. This extensive list underscores Julia Wallace’s dedication to providing a thorough and varied educational experience, aimed at fostering a knowledgeable and skilful workforce. Staff interviews further confirmed a high participation rate, alongside excitement among staff about the opportunities to learn and grow.  Julia Wallace supports all staff to transition through the New Zealand Qualification Authority (NZQA) Certificate for Health and Wellbeing. Staff completed related competencies and were assessed as per policy requirements. There are 17 caregivers who work in the special care unit and 13 caregivers have attained the dementia unit standards. Two caregivers were enrolled in unit standards. Two caregivers have not enrolled yet in the unit standards as they have been with the service for less than 18 months.  There are 12 RNs, and 10 of these RNs maintain competencies to conduct interRAI assessments. The clinical manager and unit coordinators have also maintained interRAI competencies. RNs have access to clinical trainings and they maintain syringe driver competencies. |
| Subsection 2.4: Health care and support workers  The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten staff files reviewed (the clinical manager, hospital unit coordinator, two RNs, three caregivers, one activities coordinator, lead maintenance staff and one kitchen staff) evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation. An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position and monitored from the e-learning platform. Employment records included signed code of conduct and house rules.  A register of practising certificates is maintained for all health professionals. The appraisal policy is implemented, and all staff files reviewed have an annual appraisal completed. |
| Subsection 3.2: My pathway to wellbeing  The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing. | FA | A total of six files sampled identified that initial assessments and initial care plans were resident centred, and these were completed in a timely manner. The files reviewed included three rest home (including one serviced apartment and one on transitional funding), two hospital, and one dementia level resident. InterRAI assessments were completed within 21 days of admission. Nutritional requirements forms were updated following interRAI assessments. The service uses assessment tools that include consideration of residents’ lived experiences, cultural needs, values, and beliefs. Nursing care is undertaken by appropriately trained and skilled staff including the nursing team and care staff. Resident, family/whānau, and general practitioner (GP) / nurse practitioner (NP) involvement is encouraged in the plan of care.  A contracted GP and NP visit weekly, and the NP provides a second visit on Fridays. The GP or NP completed the residents’ medical admission within the required timeframes and conduct medical reviews promptly. Completed medical records were sighted in all files sampled. The NP interviewed confirmed that communication was conducted in a transparent manner, medical input was sought in a timely, logical manner, and medical orders were followed appropriately. Mental health services are readily available as required. Residents’ files sampled identified service integration with other members of the health team. Multidisciplinary team (MDT) meetings were completed annually. There is a contracted podiatrist who visits the service regularly, and a recently contracted physiotherapist who completes assessments of residents and manual handling training for staff. Notations from the previous physiotherapist were clearly written, informative and relevant. A physiotherapy assistant is employed for three hours a day, five days a week to ensure physiotherapy plans are fully implemented.  The RN’s reported that sufficient and appropriate information is shared between the staff at each handover. The handover is both digital and verbal. Interventions were resident focussed and provide detail to guide staff in the management of each resident`s care.  Any incident involving a resident reflected a clinical assessment and a timely follow up by registered nurses. Family/whānau were notified following incidents. Opportunities to minimise future risks were identified by the unit coordinators in consultation with the registered nurses and care staff.  Progress notes were completed on every shift and more often if there were any changes in a resident’s condition. Wound management plans were implemented with regular evaluation completed (including photos) and wound care nurse specialists were consulted when required. There are no current pressure injuries.  Where progress was different from expected, the service, in collaboration with the resident or EPOA and family/whānau responded by initiating changes to the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents’ needs. EPOA’s, family/whānau and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes.  The following monitoring charts were completed in assessing and monitoring residents: fluid balance charts; intentional rounding, weights, turn charts, bowel charts, neurological observations forms, blood glucose, and restraint monitoring charts.  The Māori health care plan reflects the partnership and support of residents, family/whānau, and the extended whānau as applicable to identify their own pae ora outcomes in their care and support wellbeing. Tikanga principles were included within the Māori health care plan. Any barriers that prevent tāngata whaikaha and whānau from independently accessing information or services were identified and strategies to manage these are documented. The staff confirmed they understood the process to support residents and whānau. There were residents who identified as Māori at the time of the audit. Staff confirmed on interview that their cultural needs were being met. The cultural safety assessment process validates Māori healing methodologies, such as karakia, Rongoā, and spiritual assistance. Cultural assessments were completed by the nursing team who have completed cultural safety training in consultation with the residents, family/whānau and EPOA. |
| Subsection 3.4: My medication  The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policy is current and is in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management is in use. The system described medication prescribing, dispensing, administration, review, and reconciliation. Administration records were maintained. Medications are supplied to the facility from a contracted pharmacy. The GP and NP have completed three-monthly medication reviews as sighted in medication records reviewed.  A total of 12 medicine charts were reviewed. Indications for use were noted for pro re nata (PRN) medications, including over-the-counter medications and supplements on the medication charts. The effectiveness of PRN medications was consistently documented in the electronic medication management system and progress notes. Allergies were indicated, and all photos uploaded on the electronic medication management system were current. Eye drops were dated on opening.  Medication reconciliation was conducted by the nursing team when a resident is transferred back to the service from the hospital or any external appointments. The nursing team checked medicines against the prescription, and these were updated in the electronic medication management system. Medication competencies were current, and these were completed in the last 12 months for all staff administering medicines. Medication incidents were completed in the event of a drug error and corrective actions were acted upon. There were no expired or unwanted medicines. Expired medicines were being returned to the pharmacy promptly. Monitoring of medicine fridges and medication rooms temperatures was being conducted regularly and deviations from normal were reported and attended to promptly. Records were sighted.  Controlled medication is securely stored, and weekly and six-monthly drug checks are completed. Internal audits provide additional checks however not all entries in the controlled drug register adhere to legislative requirements.  Medications were observed to be administered safely and correctly. Medications were stored safely and securely in the trolley, locked treatment rooms and cupboards. There were four residents (two hospital and two rest home) who self-administer medications. All self-medicating documentation was in place, including consent. The medications were stored safely. There were no standing orders in use. |
| Subsection 3.5: Nutrition to support wellbeing  The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people’s nutrition and hydration needs are met to promote and maintain their health and wellbeing. | FA | A chef manager oversees food services. There is a four-week menu which is approved by the Ryman dietitian. The food control plan expires on 9 May 2024. The chef interviewed stated that they are able to manage all nutritional and dietary requirements, including those required by different cultures. Nutritious snacks are available 24/7. |
| Subsection 3.6: Transition, transfer, and discharge  The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support. | FA | There is a documented process in the management of the early discharge/unexpected discharge plan and transfer from services. Discharges are overseen by the clinical team who manage the process until exit. All this is conducted in consultation with the resident, family/ whānau, and other external agencies. Risks are identified and managed as required.  Evidence of residents who had been referred to other specialist services, such as podiatrists, wound care nurse specialists, and physiotherapists and hospice were sighted in the files reviewed. Residents and family/whānau are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| Subsection 4.1: The facility  The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people’s sense of belonging, independence, interaction, and function. | FA | The buildings, plant, and equipment are fit for purpose at Ryman Julia Wallace and comply with legislation relevant to the health and disability services being provided. The environment is inclusive of people’s cultures and supports cultural practices.  The current building warrant of fitness expires 9 December 2024. There is an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Essential contractors/tradespeople are available 24 hours a day as required. Hot water temperature recording reviewed had corrective actions undertaken when outside of expected ranges. |
| Subsection 5.2: The infection prevention programme and implementation  The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | FA | The infection prevention and control programme is appropriate for the size and complexity of the service. The programme is linked to the quality improvement programme and approved by the governing body. The infection control policies were developed with input from infection control specialists and these comply with relevant legislation and accepted best practice. The clinical manager is the infection control officer. Along with the expertise from the Ryman head office, the clinical manager advise staff on the management of infection control issues and the completion of audits. Staff interviews confirmed that infections are managed appropriately, reflecting adherence to established protocols.  A review of staff training records evidenced that staff mandatory infection control and prevention training was up to date with a high number of staff attending. Staff have received education in infection control at orientation and through ongoing annual online education sessions. Additional staff education around the prevention and management of infectious outbreaks is ongoing. This includes reminders about handwashing and advice about remaining in their room if they are unwell. Staff who were interviewed demonstrated a good understanding of infection control and prevention measures. |
| Subsection 5.4: Surveillance of health care-associated infection (HAI)  The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus. | FA | The infection surveillance program is tailored to the facility's size and service complexity, with thorough monitoring and management of infections. An infection control manual provided by an external provider is used as reference for best practice around infection control. Advice around infection control matters is also sought from the regional operations manager (RN), local infection control specialist in Regional Public Health and by liaising with GPs/NP.  Monthly data on various infections, including those affecting the urinary tract, skin, eyes, respiratory system, and wounds is meticulously collected, based on signs, symptoms, and infection definitions. This information is logged into an electronic infection register and detailed in a monthly infection summary, where infections, including specific organisms, are reviewed. Subsequently, action plans are formulated and executed, which is also analysed monthly and annually for trend identification. Additionally, the infection control data captures information on ethnicity.  To support infection prevention, audits are regularly conducted, covering areas such as cleaning, laundry, use of personal protective equipment (PPE), and the procedures for donning and doffing PPE, as well as hand hygiene practices. Where necessary, corrective measures are taken. Staff are kept up to date on infection rates and outcomes of regular audits during staff meetings, with evidence documented in the minutes of these meetings.  The facility experienced eight COVID-19 outbreaks, though they were largely contained with typically only 2-3 residents affected in each instance, demonstrating effective management and containment. Training and debriefing sessions were conducted after these events. Additionally, there was a single gastroenteritis outbreak in 2023 impacting 46 residents and 25 staff members. In response to this event, comprehensive training was provided, and discussions were held during meetings to prevent future occurrences. |
| Subsection 6.1: A process of restraint  The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | FA | Achieving a restraint-free environment is the aim of the service. Policies and procedures meet the requirements of the standards. The regional restraint group is responsible for the Ryman restraint elimination strategy and for monitoring restraint use in the organisation.  If a Māori resident requires restraint, cultural advice is sought with whānau input to explore spiritual and cultural values prior to the decision to use restraint being made. The restraint coordinator (hospital unit coordinator) interviewed confirmed that the service is committed to a restraint-free environment in all its wings. They have strong strategies in place to eliminate the use of restraint.  There is currently one restraint in use in the form of bedrails. The bedrails have been requested by the resident to assist with bed mobility. When restraint is used, this is a last resort when all alternatives have been explored. Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques. |

# Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 3.4.1  A medication management system shall be implemented appropriate to the scope of the service. | PA Moderate | Controlled drugs legislation requires two signatures in the controlled drug register to confirm administration when medications are administered; however, this was not consistently evidenced. There are two signatures recorded on the administration signing sheet as per policy. The service implemented a corrective action plan on the day of audit to prevent recurrences. | There are entries in the controlled drug register in rest home and hospital where controlled drugs have been administered and signed with one signature only. | Ensure that there are two signatures when controlled drugs are administered on the controlled drug register.  60 days |

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

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

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End of the report.