

Bruce McLaren Retirement Village Limited - Bruce McLaren Retirement Village Limited

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, 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:	Bruce McLaren Retirement Village Limited
Premises audited:	Bruce McLaren Retirement Village Limited
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: 5 September 2018 End date: 6 September 2018
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit: 115

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

Bruce McLaren facility is part of the Ryman group providing care for up to 158 residents in the care centre and serviced apartments. On the day of audit, there were 115 residents.

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

The village manager has been in the role for nine months and with Ryman for 10 years. She is supported by an assistant to the manager and acting clinical manager. The management team is supported by the Ryman management team including a regional manager.

There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisation's quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

There were no areas for improvement identified at this audit.

The service is commended for achieving continuous improvement ratings around good practice, reduction of falls, activities and food services.

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.

All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established and implemented Māori health plan in place. Individual care plans reflect the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an adverse event or has a change in their health condition. Families and friends are able to visit residents at times that meet their needs. There is an established system that is being implemented for the management of complaints.

Organisational management

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

Standards applicable to this service fully attained.

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

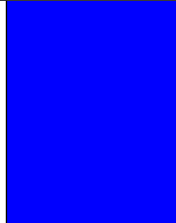
A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided onsite seven days a week with additional on call cover 24/7. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are six rooms which share communal showers/toilets. All other rooms have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management. There are sufficient civil defence supplies on-site including food, water and emergency power. There is a first aider on-site at all times.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraints or enablers during the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (acting clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

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	3	42	0	0	0	0	0
Criteria	4	89	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Thirty-one staff (three-unit coordinators, four registered nurses (RNs), 12 caregivers, one diversional therapist, two activity coordinators, one chef, one maintenance person, two health and safety representatives, one cleaner and one laundry person) interviewed, confirmed their understanding of the Code and how it is incorporated into their working environment. Staff receive training about the Code during their induction to the service which continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (four rest home, four hospital and three dementia including one young person with a disability (YPD)). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. In the dementia unit files, the residents had activated EPOA's. All rest home and hospital files sampled also had advance directives. There are 58% of all residents who have advance directives in place.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks. Advocacy information is displayed. Residents and family have access to Age Concern representatives.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend community events outside of the facility including inter-home visits and church services. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and visible at the entrance to the facility and within each unit. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system.</p> <p>There have been ten resident/relative complaints for 2018 to date. There is one HDC complaint from 2017 that has been responded to in writing. The service is awaiting feedback from the HDC.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about consumer rights. There is also the opportunity to discuss aspects of the code of rights during the admission process. 12 relatives (of three rest home, three hospital and six of dementia care residents) and seven residents (three hospital and four rest home) interviewed, confirmed that they have been provided with information on the code of rights. Code of rights posters are displayed throughout the facility. The village manager and acting clinical manager reported having an open-door policy and described the process around discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any</p>

		liability for payment for items not included in the scope. This is included in the service agreement.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being done. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with local iwi and other community representative groups. Family/whānau involvement is recognised and acknowledged by staff. There were three Maori residents on the day of audit with Maori health plans which identified they did not have any specific cultural requirements.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered, and that staff acknowledge their cultural and spiritual values. The service celebrates cultural days including Matariki. Church services are held at the facility.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.

harassment, sexual, financial, or other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly at head office by the appropriate person. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (head office) for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the team Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The service has been successful in reducing challenging behaviours in the dementia care unit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service. The information pack is available and can be read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or changes to health occurs. Evidence of families being kept informed is documented in the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Incident/accident documentation reviewed indicated that the next of kin are routinely contacted following an adverse event. Two monthly rest home and hospital resident meetings are held in each unit. Relative meetings are held in the dementia care unit. A "village connection" newsletter is produced regularly and there are seasonal Ryman times available at the front entrance for all residents, family and community visitors. A 2018 village objective was around improving communication which has been demonstrated in survey results. The resident care plans identify the resident's main language and need for an interpreter. Access to interpreter services is available if needed for residents who are unable to speak or understand English and some staff are able to interpret in several languages.</p>
Standard 1.2.1: Governance	FA	Ryman Bruce McLaren provides rest home, hospital and dementia levels of care for up to 158 residents. There are 43 rest home beds on the first floor, and 44 hospital level beds on the second floor. Both the rest

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>home and hospital beds are approved for dual purpose. The secure dementia unit is located on the third floor and is separated into two secure wings (20 beds, and 21 beds) that are joined by a nurse's station. Thirty beds in the serviced apartments across four levels have been approved for rest home level of care.</p> <p>There were 115 residents in the facility on the day of audit. This included 34 rest home level residents with 1 in a serviced apartment and 45 hospital level residents. All rest home and hospital level residents were on the aged residential care contract (ARCC). Thirty-six residents were in the two secure dementia units with eighteen residents on each wing. One resident in the dementia unit was on the young person with a disability (YPD) contract and the remaining residents were on the ARCC.</p> <p>Ryman Healthcare objectives and quality initiatives from an organisational perspective are set annually and Bruce McLaren has also developed their own specific objectives. Objectives are reviewed by the management team three-monthly.</p> <p>The village manager (non-clinical) commenced employment in December 2017. She previously was an assistant manager at another Ryman facility and has worked for Ryman for a total of ten years. The village manager is supported by a clinical manager and an assistant to the manager. The clinical manager's role was vacant at the time of this audit, with the unit coordinator/RN from the dementia unit appointed to the acting clinical manager's role. A new clinical manager will begin employment on 18 September. She is a New Zealand registered nurse (2004) and previously was the regional clinical manager for a large community-based health service.</p> <p>In addition to the dementia unit, unit coordinators are appointed to the rest home, and hospital floors (registered nurses) and the serviced apartments (enrolled nurse). The unit coordinator for the serviced apartments was vacant at the time of the audit, and was being filled in the interim with a senior caregiver. This role has been filled by an enrolled nurse who begins employment on 12 September.</p> <p>The village manager has maintained at least eight hours to date of professional development activities related to managing a hospital and village.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	<p>FA</p>	<p>The clinical manager and assistant to the manager are responsible during the temporary absence of the village manager, with added support provided by the regional manager and unit coordinators.</p>

services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Ryman Bruce McLaren has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance are reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly and family meeting are scheduled six-monthly. Minutes are maintained. Annual resident and relative surveys are completed with the last survey completed in February 2018. Results are benchmarked against all Ryman facilities. February results indicated that Bruce McLaren ranked #4 out of 31 facilities.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes. Staff are asked to sign new policies after they have read them.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, and policies/procedures are developed, implemented and regularly reviewed meeting sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and identify trends in the data. Trend analyses include collating the times and locations of adverse events. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes. A number of strategies are being implemented to reduce the number of residents' falls.</p> <p>An internal audit programme is being implemented. Areas identified for improvements are documented as a quality improvement plan (QIP). QIPs for 2018 include improvements identified around laundry, housekeeping and food. QIPs were also documented following analyses of the staff survey results, and the myRyman electronic clinical records implementation.</p> <p>Health and safety policies are implemented and monitored. Two health and safety officers were interviewed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the</p>

		<p>service and staff so that improvements are made. The data is tabled at staff and management meetings. Contractors are formally inducted into the Ryman health and safety processes. Ryman has achieved tertiary level ACC Workplace Safety Management Practice (expiry 31 March 2019).</p> <p>The service has achieved a continuous improvement in relation to their management of quality data and in particular, maintaining a low falls rate.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of a sample of 10 incidents and accidents for 2018 identified that all forms are fully completed and include follow-up by a registered nurse. Adverse events are documented electronically on V-care. All clinical events are followed up by a registered nurse. Neurological observations are completed if there is a suspected injury to the head.</p> <p>The village manager was able to identify potential situations that would be reported to statutory authorities with one example provided where a Section 31 report was filed for a police investigation of an absconding resident.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (one chef, one-unit coordinator/RN, four staff RNs, one activities coordinator, six caregivers) included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in, and completed general and job-specific induction checklists. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. Journal club meetings are provided for nursing staff two monthly. Nine of sixteen registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including but not limited to medication</p>

		<p>competencies and insulin competencies.</p> <p>Seventeen of twenty-seven caregivers who work in the dementia unit have completed their dementia qualification. The remaining ten caregivers have been employed for less than one year in the dementia unit and are in the process of completing their qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<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>The facility covers four floors with an elevator and stairs for access. The clinical manager's role was vacant at the time of the audit. This registered nurse (RN) vacancy has been filled and the new clinical manager will begin employment later mid-September. The unit coordinator/RN in the dementia unit has been filling the role in the absence of the clinical manager over a four-week period of time until the new clinical manager starts. The new clinical manager that has been employed is a registered nurse with a current practising certificate who will work full time Tuesday - Saturday.</p> <p>There are four-unit coordinator positions. The position for the unit coordinator/enrolled nurse (EN) in the serviced apartments was vacant. This position was being filled on an interim basis by a senior caregiver. One-unit coordinator/RN is assigned to the dementia unit, One-unit coordinator/RN is assigned to the hospital and one-unit coordinator/RN is assigned to the rest home. The unit coordinators stagger a seven day a week schedule to ensure that there is a minimum of one-unit coordinator available seven days a week on the AM shift. The Clinical Manager and Unit coordinators share an on-call roster with one of them being available on-call 24 hours a day, seven days a week.</p> <p>There are thirty serviced apartments certified to provide rest home level of care that span four floors with one rest home level resident during the audit. A senior caregiver is staffed seven days a week from 0800 – 1630. They are supported by two caregivers on the AM shift (0700 – 1300 and 0800 – 1300), and two caregivers on the PM shift (1600 – 2100 and 1630 – 1900). The caregivers in the rest home cover the serviced apartments after 2100. Staff communicate via mobile telecommunications.</p> <p>The rest home unit is on the ground level. There were 32 rest home level residents and seven hospital residents. The unit coordinator/RN works the AM shift Tuesday – Saturday and a second RN covers the AM shift on Sunday and Monday. There are six caregivers on the AM shift (three long and three short), four caregivers on the PM shift (two long and two short) and two activities staff (one is Monday – Friday 0930 - 1630 and one is two days a week (Mondays and Wednesdays) from 1300 – 1630. The night shift is staffed with two caregivers.</p> <p>The hospital is on the first level. There were 38 hospital and one rest home resident. The unit coordinator/RN works on the AM shift Sunday – Thursday. Two staff RNs cover the AM and PM shift and one RN covers the night shift, seven days a week. There are eight caregivers on the AM shift (four long</p>

		<p>and four short) and one fluid assistant from 0930 – 1300. There are six caregivers on the PM shift (two long and four short) and one lounge carer from 1600 – 2000. Three caregivers cover the night shift. Activities cover is seven days a week with two activities staff rostered on Tuesdays and Thursdays.</p> <p>The dementia unit is broken down into two separate, locked/secure wings that are joined by one nursing station. Each wing had 18 residents and one day stay resident from rest home with written approval by the DHB mental health service. Consent had also been obtained from family for environmental restraint. The dementia units were staffed with two RNs on the AM and PM shifts (including the unit coordinator/RN (interim clinical manager). One long and one short caregiver are rostered in each dementia wing on the AM and PM shifts. A lounge carer/diversional therapist covers from 0900 – 1600 and a diversional therapist covers from 0930 – 1800. The PM is staffed with one lounge caregiver from 1600 – 2000. The night shift is staffed with three caregivers across the two wings.</p> <p>Separate cleaning and laundry staff are rostered.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident computerised files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry including information on the dementia are unit. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the CMDHB 'yellow envelope' transfer system. Communication with family is made.</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 comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. All policies and procedures had been adhered to. There were no standing orders. There were no vaccines stored on site.</p> <p>The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RN's and senior medication competent caregivers administer medications. All staff have up to date medication competencies and there has been medication education this year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature in each area is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twenty-two medication charts were reviewed. Medications are reviewed at least three monthly by the GP. The GP and the psychiatrist review the medications for dementia care residents. There was photo identification and allergy status recorded. As required medications had indications for use prescribed. The effectiveness of as required medications is recorded in the progress notes and on the electronic medication system.</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>	<p>CI</p>	<p>The qualified head chef is supported by a second chef on duty, cook's assistants and kitchenhands. Staff have been trained in food safety and chemical safety. All meals and baking are prepared and cooked on-site. The food control plan has been verified and expires 9 May 2019. The seasonal menu has been designed in consultation with the dietitian at an organisational level and seeks feedback from residents. Project "delicious" has been in place since January 2017. Menu choices are decided by residents (or primary care staff if the resident is not able) and offer a variety of choices. Diabetic desserts and gluten free diets are accommodated as required. Meals are delivered in hot boxes and served from bain maires in the unit kitchens. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident dislikes are accommodated and listed on the daily spreadsheet. Alternative foods are available on the menu or offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are delivered regularly to the dementia care units. Fortified meals are provided on RN/dietitian request. Pureed foods are brought in that have a higher nutritional value.</p>

		<p>Freezer and chiller temperatures and end cooked, re-heating and serving temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings, resident survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long- term residents whose files were sampled. Behaviour assessments had been completed for the files of three dementia care residents with the outcomes included in the care plan. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) nutrition and continence.</p> <p>The service has introduced the myRyman electronic resident individualised care programme. There are a number of assessments completed that assess resident needs holistically. The assessments generate interventions and narrative completed by the RNs that are transferred to the care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated were included in progress notes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>and strategies for de-escalation including activities. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people.</p> <p>The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Residents and relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident. This was integrated into the electronic myRyman individualised record</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given [sited]). Monitoring charts are well utilised. Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Resident falls are reported electronically and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. There are currently sixteen wounds being treated. One chronic wound has had input from the GP and wound care nurse specialist and there are photos of the wound's progress. One wound has been referred to the vascular surgeon. There are currently three stage two pressure injuries. A review of all three, identified documentation was fully completed. One is non-facility acquired. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position on myRyman.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>In the rest home there is one activities coordinator working 0930-1630 Monday to Friday and there is an activities assistant working 1300 to 1630 Monday to Wednesday. In the hospital there is an activities coordinator working 0930-1630 seven days a week and an activities assistant working 1300-1630 Tuesday to Thursday. Both activities coordinators are completing the diversional therapy (DT) course. A qualified DT is employed in the dementia care unit from 9.30am to 6pm. She is supported by a lounge carer (also a DT) seven days a week. There is an activity team member in each dementia care unit. On the days of audit, residents in all units were observed doing Triple A exercises, playing bingo, listening to entertainment and taking part in quizzes.</p> <p>There is a weekly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside. The rest home, hospital and serviced apartments combine for some activities. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. There are van outings twice weekly in the rest home and hospital and weekly outings for dementia care residents in both units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision. Activities in both the dementia care units include triple A exercises, garden walks, singing, happy hours, hand therapy, foot spas, bread making, word games, men's group, group dancing and adult colouring.</p> <p>There is an interdenominational church service every Wednesday and Catholic volunteers come in to give communion in the rest home, hospital and dementia care units.</p> <p>There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and the Melbourne Cup are celebrated. Recently during Matariki a Kapa Haka group visited. They have also just had a month of learning poi. There is pet therapy monthly and the staff also bring in their pets.</p> <p>There is community input from pre-schools and schools, 'baby ballerinas', and health camp children. Residents go out to Cafe Musica, the health camp and the RSA. The "village friends" are involved in the activity programme in all areas.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held two monthly. Residents and relatives expressed satisfaction with the activities offered. There are activities offered in addition to the engage programme that has shown an increase in resident satisfaction in the February 2018 annual survey results.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Nine care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Two residents had not been at the service long enough for a review. Acute care plans for short- term needs (in myRyman) are evaluated and signed off as resolved or added to the long- term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, CG, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are invited to the MDT review and if unable to attend are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people and a vascular surgeon. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. There are sluices on each care centre floor.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The building holds a current warrant of fitness which expires 14 October 2018. There is a maintenance person who works full-time. There is an assistant maintenance person who works three days a week. Contractors are available when required. There is also a full-time head gardener who has two full time</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>assistants.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a small upstairs outdoor balcony area in the hospital and a larger secure one in the dementia unit. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All rooms have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs and privacy locks on all shower/toilet doors. There are communal toilets near all communal lounges.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There are three double rooms on each floor in the rest home and in the hospital. At present these all are only occupied by one resident. All other rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	<p>FA</p>	<p>There are large and small communal areas in the rest home and hospital. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. In the dementia unit there is a large lounge in each unit and there are spacious dining rooms in each unit. There is a shop, reflection room, hairdressing salon and beauty salon in the village centre. The village has</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>a gym, pool and bowling green which residents may use if able.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away when not in use. All chemicals on the cleaner’s trolley were labelled. There are sluice rooms on each floor for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept locked when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Staff have attended emergency and disaster management training and six-monthly fire drills. There is an approved fire evacuation plan dated 10 November 2014. There is a first aid trained staff member on every shift. There are sufficient civil defence kits in the facility and adequate ceiling tanks water storage and bottled water in the care centre. There is adequate food available for at least three days. There is gas and electric cooking in the kitchen and three barbeques available. There are six generators to cover the care centre and the village. Smoke alarms, sprinkler system and exit signs in place. The facility is secured at night. There are call bells in all resident rooms, toilet/shower areas and communal areas.</p> <p>The “Austco Monitoring programme” call bell system is available in each bedroom. There are call bells in common areas. There is a nurse presence bell when a nurse/carer is in the resident room a green light shows staff outside that a colleague is in a particular room. The call bell system has a cascading system of call recognition that will cascade if not responded to within a certain time from the primary nurse (caregiver) to the nurse coordinator, to the clinical manager and to the village manager. The system software is able to be monitored. The system includes the latest electronic beam management technology which will be used to alert staff on the movements of residents in their rooms who are at high risk of falling. Alerts will be sent electronically to staff for those high-risk residents who are attempting to get of bed unsupervised.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. and there is underfloor heating as well. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free.</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme are appropriate for the size and complexity of the service. The infection control and prevention officer is the dementia care coordinator who has just taken on the role and completing induction to the infection control role. The infection prevention and control committee are combined with the health and safety committee, which meets two monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitizers are placed appropriately within the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control committee (combined with the health and safety committee), is made up of a cross-section of staff from all areas of the service. The infection control officer has completed an infection control study day March 2018 and attends Ryman skype seminars for infection control officers.</p> <p>The infection and prevention officer have access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.</p>

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the v-care system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There has been one confirmed sapovirus outbreak in the dementia care unit in July 2017. Relevant authorities were notified (sighted). Daily case logs and correspondence were sighted.</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. The facility has remained restraint-free (no restraints or enablers) since their last audit.</p> <p>The restraint coordinator is a unit coordinator/RN at rest home level. Staff training is provided a minimum of</p>

		annually around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>In June 2017 the service identified an improvement was required around reduction of challenging behaviours in the dementia care unit. In May 2017 challenging behaviours rose to 3.2/1000 bed nights when this had previously been 1.7/1000 bed nights. The service has been successful in reducing challenging behaviour rates to below the lower limit of 1/1000 bed nights.</p>	<p>To achieve reduction in challenging behaviour incidents in the dementia care unit the following was implemented; a) further education for staff around triggers, de-escalation and activities, b) employment of a lounge carer in the evenings to ensure needs of residents with challenging behaviour were being met including one on one time, c) regular reviews of clinical data to identify trends, d) close monitoring of residents by staff including the DT during activities and e) regular medication reviews by the GP and the visiting mental health nurse and psychogeriatrician. The individual care plans describe the resident's behaviours, triggers and interventions including activities. Staff know the residents very well including triggers for behaviours and intervene before behaviours escalate. Since the implementation of the above strategies the challenging behaviour incidents have reduced below 1/1000 bed nights over the past eight months with two months having zero incidents. This has resulted in a calm environment in the dementia care unit and less distress for residents. The service has achieved its goal in reducing challenging behaviour incidents from 3.2/1000 bed nights to 1/1000 to zero bed nights.</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality indicator data is collected, collated, analysed with feedback provided to staff. Quality improvements around falls prevention has resulted in a rating of continuous improvement.</p>	<p>A review of the benchmarked data for the 12-month period ending August 2018 evidenced that the falls have been maintained below the upper limit of 11/1000 bed nights for hospital and rest home level residents since the implementation of falls prevention strategies. Strategies include a colour coding (traffic light) system, providing falls prevention training for staff, ensuring adequate supervision of residents, and encouraging resident participation in the activities programme. Other initiatives include physiotherapy assessments for all residents, routine checks of all residents specific to each resident's needs (intentional rounding), the use of sensor mats, the use of night lights, and increased staff awareness of residents who are at risk of falling.</p> <p>Caregivers and RNs interviewed were knowledgeable in regards to preventing falls and identified those residents who were at risk. The caregivers confirmed that they have more face-to-face time with residents since the implementation of myRyman which allows for more time observing residents and attending to their needs. Fall free days are celebrated by staff.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>Ryman has introduced a number of systems to ensure residents nutritional needs are met and the dining experience improved. This has been achieved with the introduction of project delicious in January 2017.</p>	<p>The four-week rotating seasonal menu offers a variety of choices including three main dishes for the midday and two choices for evening meal including a vegetarian option. There is a chef's choice and resident choice weekly. Gluten free meals are offered on the menu. Cultural dietary needs are met through the project delicious menu. The service has liaised with food suppliers to improve quality of suppliers including access specialised pure foods for pureed options. There has been feedback and consultation with residents on the new menu with concerns and feedback noted and changes made such as re-wording of some menu foods as residents unfamiliar with the dish and some food items not appealing. This feedback led to changes over the winter menu. Other initiatives include an easy to read laminated menu card for ease of weekly ordering with staff assistance as needed. There has been ongoing education for staff around food services and nutrition and hydration. The dining experienced has improved through staff etiquette, meal choices and presentation and a relaxed rather than rushed meal time as observed in the dining areas of each unit on the day of audit.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are</p>	CI	<p>Each unit has provided additional activities that focus on engagement</p>	<p>The rest home residents are actively engaged with a local junior school child who visit the residents weekly. The school children and residents enjoy sharing the newer and older games together and reminiscing. The resident then attends the school with the children</p>

<p>planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>with the community (rest home) use of technology (hospital) and small group activities (dementia care unit). The service has been successful in providing meaningful activities that are relevant to the resident groups.</p>	<p>and enjoy being with the children as they show the residents their computers and school work.</p> <p>Recently the hospital activities coordinator has introduced a computer corner with computer and headphones where residents can enjoy documentaries and other programmes of their choice. The resident who first asked to use a computer is now teaching other residents how to use it. They have now formed a computer club. There is also an Alexis programme which is similar to Siri. When residents ask Alexis a question and she answers back to them. Alexa can play music, make calls, set music alarms and timers.</p> <p>There are weekly outings for residents in the dementia unit 1 (21 beds) and unit 2 (20 beds). Outings include places of interest including beaches, airport, parks and Bays, Eden park, Buddhist temple and viaduct. Records demonstrate good numbers of residents going on outings averaging 18-20 residents each time. There is an active men's group and smaller groups have been formed including singing group, dancing group, group walks in the village, gardening group. The smaller interest groups have contributed to reduction of challenging behaviours (link 1.1.8.1).</p> <p>Resident and relative meeting minutes sighted document complimentary comments on the activities in each unit. Residents and relatives interviewed on the day of audit expressed they were very satisfied with the activities and outings provided and they are invited to events and celebrations such as barbeques. The February 2018 resident/relative survey demonstrated an increase in satisfaction with activities from 3.74 in 2017 to 4.55 in 2018.</p>
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End of the report.