

Murray Halberg Retirement Village Limited - Murray Halberg Retirement Village

Introduction

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

The audit has been conducted by 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:	Murray Halberg Retirement Village Limited
Premises audited:	Murray Halberg 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: 4 August 2020 End date: 5 August 2020
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:	54



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

Murray Halberg is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 160 residents. There were 54 residents at the time of the audit.

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, family, management, and staff.

The village manager is appropriately qualified and experienced and is supported by a regional manager, a regional quality manager, a resident services manager, and a clinical manager/registered nurse. One unit coordinator is employed for each level of care (hospital, rest home, dementia and serviced apartments). There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit identified that one improvement is required around documenting resident interventions.

Consumer rights

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

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference 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 if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets timeframes determined by HDC.

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, resident services manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews.

Quality and risk management programmes are being implemented. Corrective actions are established 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. Education and training for staff includes in-service education and competency assessments.

Nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
--	--	---

There is an information/welcome pack that includes information on each level of care. Registered nurses are responsible for initial assessments, risk assessments, interRAI assessments, and development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, are individualised and evaluated six-monthly. The general practitioner reviews residents on admission and at least three-monthly.

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

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

Meals are prepared on site. The 'project delicious' menu is designed by a dietitian at organisational level and provides meal options including gluten free and vegetarian. Individual and special dietary needs are catered for. 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.
--	--	--

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

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.
---	--	--

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. The service had no residents assessed as requiring either the use of restraint or the use of an enabler. Staff receive ongoing education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

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 coordinators are responsible for coordinating/providing education and training for staff. The infection control coordinators have completed training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. Information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	1	0	0	0
Criteria	0	92	0	1	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 Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as part of their annual in-service programme and competency assessment.</p> <p>Interviews with nineteen staff (five caregivers on the am and pm shifts [one serviced apartment, one dementia (special care unit) , three rest home/hospital], five nursing staff (three-unit coordinators/registered nurses [RNs], one unit coordinator/enrolled nurse [EN] one staff nurse, one lead chef, two maintenance, one laundry, one cleaner, one dietitian, one physiotherapist and two activity coordinators) confirmed their understanding of the Code. Staff interviewed could provide examples of how the Code applies to their job role and responsibilities. Five residents (two rest home [one care centre and one serviced apartment] and three hospital) and five relatives (one rest home and four dementia) interviewed confirmed that staff uphold the rights of residents.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	FA	<p>Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. Specific consents were viewed for wound photographs and influenza vaccines. Eight resident files reviewed (three rest home including one resident in a serviced apartment, three hospital level of care residents including one in a serviced apartment and two dementia level of</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>care residents) included written consents.</p> <p>Advance directives and/or resuscitation status are signed for separately by the competent resident. Where the resident is unable to make a decision, the GP makes a medically-indicated not for resuscitation order in consultation with the enduring power of attorney (EPOA). The EPOA for the two dementia level of care residents had been activated. Copies of EPOA and activation status are available on the resident's electronic myRyman file under the EPOA icon. Caregivers and registered nurses (RN) interviewed confirmed verbal consent is obtained when delivering cares. Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Admission agreements for the eight long-term resident files reviewed had been signed within a timely manner.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with family confirmed the service provides opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</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 families interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes includes opportunities to attend events outside of the facility. There is an on-site café. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain actively involved in community and external groups. Families 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. Information about complaints is provided on admission and on noticeboards. Interviews with residents and family members confirmed their understanding of the complaints process. Complainants are provided with information on how to escalate their complaint if resolution is not to their satisfaction. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register is in place. Only one complaint has been lodged since the care centre opened. This complaint was investigated and resolved within timeframes determined by HDC. There is evidence of</p>

		<p>this complaint being discussed in staff and management meetings with appropriate follow-up actions taken. This complaint is documented as resolved.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Aspects of the Code are discussed during the admission process with the resident service manager. Residents and relatives interviewed confirmed that information had been provided to them about the Code. Large print posters of the Code and advocacy information are visually displayed throughout the facility on noticeboards.</p> <p>Families and residents are informed of the scope of services and any liability for payment of items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms and closing doors while cares were being given. Staff interviewed were able to define abuse and neglect and its application to an aged care environment. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident care provision.</p> <p>Instructions provided to residents on entry regarding responsibilities of personal belongings is in their admission agreement.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has implemented a Māori health plan. A letter of invitation was sent to local iwi (Ngati Whatua) to inform them of the new village and invite them to tour the facility. Village events associated with Māori language week were highlighted in the letter. Plans are in place to hold a Māori blessing at the opening of the facility, scheduled to take place in September 2020.</p> <p>There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the resident's care plan. At</p>

		the time of the audit, no residents identified as Māori.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau are invited to be involved. Individual beliefs and values are also discussed and incorporated into the resident's care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with residents and family confirmed that residents' values and beliefs are considered. One resident who identified with her Pacific Island culture had cultural items displayed in her room and confirmed her cultural needs were being met by the service.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include the role and responsibilities of the position. The monthly full facility meetings include discussions on professional boundaries and concerns as they arise. Interviews with managers (regional manager, village manager, clinical manger, resident services manager) and staff, confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of 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.</p> <p>A range of clinical indicator data is collected for each service level. It is reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include (but are not limited to) resident incidents by type, resident infections by type, staff incidents or injuries by type. Feedback is provided to staff. Quality improvement plans (QIPs) are developed where results do not meet acceptable targets. Since the facility opened (October 2019), 16 QIPs have been implemented with 12 of the 16 closed. Work continues around reducing residents' falls, ensuring the timeliness of interRAI assessments, wound care documentation and attendance at full facility staff meetings.</p> <p>A recent staff satisfaction survey reflected a ranking of 6 out of a total of 34 care centres with a 94% response rate. This positive outcome has been shared with the staff and the residents. Areas highlighted as strengths included: keeping people safe and well at work; person they report to is approachable; they were informed about Ryman's Covid 19 response plan, there is an organisational commitment to staff general wellbeing. A resident satisfaction survey has not been completed yet. Courtesy calls were recently undertaken with positive results and feedback.</p> <p>The myRyman electronic resident information (eg, care plans, monitoring charts) have been implemented</p>

		<p>that allow for one-on-one time with residents and less paper-based documentation. Interventions (eg, weight management, falls management strategies, pain management, neurological observations, behaviour management) documented on myRyman are reviewed by a registered nurse. MyRyman care plans provide evidence to indicate when cares are being delivered (link 1.3.6.1).</p> <p>A general practitioner or nurse practitioner visits the facility three times a week with 24/7 on-call services. Physiotherapy services are provided five days a week for a total of 20 hours. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists.</p> <p>The health and safety programme has introduced a 'stop and think' employee campaign using 'step-back' cards. Staff are involved in identifying risks and hazard controls.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Twelve adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters are available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Murray Halberg Retirement Village is a new Ryman Healthcare facility located in Lynfield, Auckland. The facility is modern and spacious and extends across a sloping section. There are 160 beds available with 38 dementia beds across two separate secure units (with a shared nursing station), and two 46 bed rest home/hospital (dual purpose) units. There were 32 residents in one dual-purpose unit (12 rest home and 20 hospital) on level three at the time of this audit. The second dual purpose unit (level two) is scheduled to open later in the year and will accommodate primarily rest home residents with the third level primarily hospital level residents. There were three residents on respite (one hospital and two rest home). All remaining residents were on the age-related residential care (ARC) contract. There were 18 residents across the dementia units (13 residents in one unit and five residents in the other unit).</p> <p>Thirty serviced apartments across three levels are certified to provide rest home level care. Of those 30 serviced apartments, nine of the apartments adjacent to the hospital/rest home on level three are also certified as suitable to provide hospital level care. During the audit, there were three hospital level residents and one rest home level resident living in a serviced apartment on level three.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually, specific to Murray Halberg. Each objective includes an action place and person(s) responsible. There are specific projects with action plans related to clinical, health & safety, human resources and resident/relative feedback.</p>

		<p>Details of progress are reported quarterly.</p> <p>The village manager at Murray Halberg has a business consultancy background and commenced in December 2018. He is supported by a resident services manager (previously referred to as an assistant to the manager), a clinical manager, a regional manager and a regional quality manager. The clinical manager (CM) has experience in hospice care as a clinical nurse specialist and was clinical manager at another Ryman facility prior to his appointment at Murray Halberg on 7 October 2019. The managers are supported by a unit coordinator (UC) in each area. The hospital, rest home and dementia UCs are registered nurses and the UC for the serviced apartments is an enrolled nurse.</p> <p>The managers have maintained more than eight hours annually of professional development related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The resident services manager and clinical manager are responsible during the temporary absence of the village manager with additional support provided by the regional manager. The UCs are responsible for clinical operations during the temporary absence of the clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management system that is directed by head office (Ryman Christchurch) is established and implemented. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with managers and staff, and the review of meeting minutes demonstrated the collective involvement of managers and staff in quality and risk management activities.</p> <p>Resident meetings are held two monthly for each service level and relative meetings are scheduled six monthly. The village manager attends the meetings, and minutes are maintained. Resident and relative surveys are scheduled to be completed annually.</p> <p>The service has policies and 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 and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. They are communicated to staff, evidenced in meeting minutes.</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, policies, and 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. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. The internal audit programme is followed as per the schedule. Three of nineteen internal audit results reflected less than acceptable outcomes (caregiver comprehension survey, fire safety/drill and continuum service delivery). A QIP was initiated for each of these internal audits. All three were signed off as meeting the acceptable threshold at the time of the audit.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Meetings are held monthly with weekly new build meetings that focus on health and safety during construction. Two health and safety officers were interviewed (both maintenance staff). Both have completed stage one health and safety training. 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 service and staff. Health and safety data is tabled at staff and management meetings. A review of the risk register and the maintenance register indicated that there is resolution of issues identified. All new staff and contractors are inducted to health and safety processes. There is also annual in-service training and competency assessments.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls with a range of examples provided (eg, providing falls prevention training for staff; ensuring adequate supervision of residents; encouraging resident participation in the activities programme; physiotherapy assessments for all residents during their entry to the service and for all residents who have had a fall; routine checks of all residents specific to each resident's needs (intentional rounding); the use of sensor mats and night lights; and increased staff awareness of residents who are at risk of falling). Caregivers and RNs interviewed were knowledgeable in regard to preventing falls and identifying those residents who were at risk. A recent increase in the number of falls has generated a QIP that was underway during the audit.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise, and debriefing. Individual incident reports are completed electronically using VCare for each incident/accident with immediate action(s) and any follow-up action required evidenced.</p> <p>A review of 12 incident/accident reports (eg, witnessed and unwitnessed falls, pressure injury,</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>challenging behaviours) included follow-up by a registered nurse. Missing was consistent evidence of timely neurological observations if there is a suspected injury to the head (link 1.3.6.1).</p> <p>The managers and unit coordinators are involved in the adverse event process via regular management meetings and informal meetings during the week that provide an opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations would be reported to statutory authorities, (eg, Section 31 reports were sighted for pressure injuries).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. Ten staff files were randomly selected for review (four caregivers, one clinical manager, one unit coordinator, two kitchen assistants, one chef, one housekeeper). Each file included an application form and two reference checks, a signed employment contract, job description, police check, and completed orientation programme. All files reviewed also included a six monthly performance appraisal.</p> <p>A register of registered nurses and one enrolled nurse current practising certificates are held on site. Practising certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. The general orientation programme that is attended by all staff covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. Staff also complete annual competency questionnaires. RNs are supported to maintain their professional competency. Five of thirteen RNs have completed their interRAI training. RNs and ENs attend journal club. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>Nineteen caregivers work in the dementia unit. Seven have completed the required dementia standards and twelve are in the process of completing theirs.</p>

		<p>There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including (but not limited to) medication competencies and insulin competencies.</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. The village manager, resident services manager and clinical manager work Monday – Friday.</p> <p>Four unit coordinators (one hospital/RN, one rest home/RN, one dementia/RN, one serviced apartments/EN) work full time. They stagger their schedules for seven day a week cover across the two units that are currently open.</p> <p>At the time of the audit, due to the resident census, the Perth wing was being used as a dual-purpose wing and the Rome wing was closed. Once the resident numbers increase, the Perth wing will be primarily hospital level and the Rome wing will be primarily rest home level.</p> <p>Perth wing (occupancy 30 hospital and 12 rest home residents): is staffed with two unit coordinators on the AM shift. One staff RN is rostered on each shift. Three long and three short caregivers are on the AM shift, two long and two short caregivers are on the PM shift and one caregiver is on the night shift. Perth wing staff are also responsible for the three hospital level residents residing in the serviced apartments (located adjacent to the Perth wing).</p> <p>Cardiff (dementia) unit is split into two wings with a shared nursing station (thirteen residents and five residents in the two wings). In addition to a unit coordinator/RN five days a week, an RN covers the AM shift seven days a week with two long and two short shift caregivers. One RN covers the PM shift five days a week with a senior caregiver rostered two days a week. The PM shift is supported by two long and one short shift caregiver. One senior caregiver is supported by a staff caregiver during the night shift. Service apartments (one rest home level resident) is staffed with one-unit coordinator/EN five days a week and a senior caregiver the remaining two days. One staff caregiver is rostered on the AM shift and the PM shift to 9 pm. After 9 pm the responsibility is delegated to a caregiver on the rest home/hospital wing (Perth). The call system is linked to their pagers.</p> <p>A 'cover pool' of staff (one RN for eight hours, seven days a week (AM or PM shift); one caregiver for six or seven hours, five days a week; and one housekeeper for four hours, seven days a week) are additional staff that are rostered to cover staff absences.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident information (hard copy and electronic) is protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation. Residents' files demonstrated 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>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well-informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry including specific information on dementia level of care and the safe environment.</p> <p>The admission agreement reviewed aligns with the services contracts for long-term.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The myRyman system has the ability to gather all relevant information together in preparation for a transfer. Transfer notes and discharge information was available in the hard copy resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All medications are stored safely in each unit. Registered nurses and senior caregivers' complete annual medication competencies and education. Registered nurses complete syringe driver training. Medication reconciliation of monthly blister packs is checked by an RN with the signature on the back of the blister pack. Any errors are fed back to the pharmacy. Monthly medication audits are completed. There is one rest home and one hospital resident self-medicating with a self-medicating assessment in place. The medication fridge temperatures are taken weekly and the room air temperatures are taken and recorded daily. Temperatures have been within an acceptable range. All eye drops, creams and sprays were dated on opening. There is a bulk supply stock for hospital residents which is checked weekly for stock levels and expiry dates. 'As required' medications and resident stock</p>

		<p>is checked monthly for expiry dates.</p> <p>The service uses an electronic medication system. Sixteen medication charts were reviewed (six hospital, six rest home and four dementia care). All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that regular medications were administered as prescribed. 'As required' medications had the indication for use documented. The effectiveness of 'as required' medications were recorded in the electronic medication system and in the progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking are prepared and cooked on site. The newly designed kitchen is located in the service area on the second level (adjacent to the rest home dual purpose unit – yet to open). The qualified lead chef is supported by a second chef on his days off. There are two cook assistants, two morning kitchenhands and two afternoon kitchenhands on duty each day. All food services staff have completed induction, food safety training and chemical safety.</p> <p>'Project delicious' is a four weekly seasonal menu with three menu choices for the midday meal and two choices for the evening meal, including a vegetarian option and gluten free foods. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Resident dislikes are accommodated. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. A weekly update on dietary requirements is received from the units. Pureed meals are provided. Lip plates are available to encourage resident's independence with meals. All meals are plated in the kitchen and delivered to the units in scan boxes. Special diets are name labelled. Coloured plates are used for dementia care residents. The food services are involved in catering for resident special events and functions and host fine dining monthly. The service also operates the on-site café.</p> <p>The service has a food control plan that has been verified and expires January 2021. The large food store area includes pantry, two chillers and walk-in freezer. Temperatures are taken and recorded for fridges, freezer, end-cooked foods and incoming goods. Each unit has a satellite kitchen and there are nutritious snacks available 24 hours. All foods were stored correctly and date labelled. The chemicals are stored safely and the chemical provider conducts checks on the dishwasher regularly. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents can provide feedback on the meals through resident meetings and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.</p>
Standard 1.3.2: Declining	FA	The service records the reason for declining service entry to potential residents should this occur and

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>In the files reviewed, risk assessments had been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural, wound and physiotherapy assessments were completed according to need. There are a number of assessments completed that assess resident needs holistically such as cultural and spiritual and activities assessments. The assessments generate interventions and narrative completed by the RNs that are transferred to the myRyman care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six-month care plan 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 plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met. The myRyman programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or recent fall, likes and dislikes. There 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</p>	<p>PA Low</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. The care plans are updated with any changes to care and required health monitoring interventions for individual residents are scheduled on the RN or caregiver work log.</p>

<p>needs and desired outcomes.</p>		<p>Wound assessments, treatment and evaluations were in place for 10 wounds in the hospital dual purpose unit (two pressure injuries, three skin tears, four lesions and one chronic ulcer) and 10 wounds in the dementia care unit (one resident with six ulcers, one resident with one ulcer and one resident with 3 surgical wounds – donor grafts and site). The two pressure injuries are the same hospital resident with a stage 3 and stage 2 pressure injury on admission with a section 31 sighted for the stage 3. There is adequate pressure relieving resources available. All wounds are linked to the care plans. Photos were taken where relevant. The clinical manager is the wound champion and reviews all wounds weekly. Referrals are made as necessary to the dietitian and wound nurse specialist. The wound champion keeps up to date with regular wound care updates via webinar sessions and formal education as offered.</p> <p>Contenance products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms are set up on the electronic work log and include blood pressure, weight, blood sugar levels, pain, behaviour, repositioning charts, food and fluids, intentional rounding and neurological observations, however not all neurological observations for unwitnessed falls had been completed as per protocol.</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>FA</p>	<p>The service currently employs one activity and lifestyle coordinator Monday to Friday and an activity coordinator for the weekends. There is one activity and lifestyle coordinator Monday to Friday for the dual-purpose hospital unit (with dementia unit standards) and a level three caregiver for the weekends. Both of the main activity and lifestyle coordinators have caregiver experience. There is an activity coordinator for the apartments Monday to Friday and a village host for the weekends. The activity team reports to the resident services manager who has been in a previous role as activity and lifestyle coordinator at another Ryman village.</p> <p>The Engage programme has been implemented. There are set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including (but not limited to); Triple A exercises, board games, news and views, make and create, poets corner, memory lane, gardening, walks, men’s group, sensory activities including pet therapy, themed events and celebrations. Rest home residents in serviced apartments can attend either the serviced apartment or rest home/hospital programmes. Hospital level residents in serviced apartments are assisted to attend the hospital/rest home activity programme.</p> <p>Some activities are integrated for all residents including weekly entertainers and happy hour and church services held in the on-site reflection room. Families are invited to attend activities. Community links include pre-school children, choir groups and pet therapy. There are weekly van outings for all residents.</p>

		<p>The service has two 11-seater vans and hires a mobility van for hospital residents.</p> <p>Resident life experiences and an activity assessment is completed for residents on admission. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. The activity plan is incorporated into the myRyman care plan and evaluated six-monthly with the MDT review. Residents/relatives can feedback on the programme through the resident and relative meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Three resident files of residents who had been at the service six months, identified that long-term care plans had been evaluated by registered nurses. Five of eight resident files were not due for a six-monthly evaluation (three hospital, one rest home and one dementia care). Care plans had been updated with any changes to health and care.</p> <p>Written evaluations describe the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. The multidisciplinary (MDT) review includes the RN, caregivers, DT, GP, physiotherapist, resident, relative and any other health professionals involved in the resident's care. A record of the MDT review is kept in the resident file. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available for all care staff and laundry/housekeeping staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are labelled correctly and stored safely throughout the facility. Safety datasheets and product information is available. The chemical provider monitors the effectiveness</p>

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		of chemicals and provides chemical safety training.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The village is operating under a certificate for public use (CPU) issued 15 October 2019 as construction has not been completed. The care centre is across three levels (level one – dementia care; level two – dual purpose rest home not yet occupied; and level three – dual purpose hospital. Serviced apartments are across levels 3, 4 and 5. Nine dual purpose serviced apartments are adjacent to the level three dual purpose hospital unit.</p> <p>The maintenance team (maintenance person and village handyman) and gardeners report to the resident services manager. The maintenance person (interviewed) is full-time and available on-call as required and has been in the role since November 2018 and involved in the construction of the village. He has completed first aid, health and safety, worksite training and chemical safety training.</p> <p>A reactive maintenance and planned maintenance schedule are maintained. There is a monthly checklist for planned maintenance including the calibration of medical equipment, functional testing of electrical equipment and hot water temperatures in resident areas. Hot water temperatures in resident areas are stable below 45 degrees Celsius. The maintenance person has completed an electrical testing certificate.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the rest home and hospital wings for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.</p> <p>Residents are able to access outdoor areas safely or with supervision. Seating and shade are provided.</p> <p>There is secure entry/exit to the two dementia units on level 1. Each unit has access to two external areas with walking pathways, raised gardens, seating and shade. The previous finding from the partial provisional audit relating to completing the landscaping of external areas has been addressed.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>All resident rooms (including the serviced apartments) have full toilet/shower ensuites. There are adequate numbers of communal toilets located near the communal areas. Toilets have privacy locks. Toilet doors in the dementia unit have large pictorials on the doors. There are sensor lights in the ensuites of the dementia level resident rooms. Non-slip flooring and handrails are in place. Residents</p>

<p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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 four double rooms in each of the units (hospital, rest home and dementia care). All other rooms are single. All bedrooms and ensuites are spacious for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The level three hospital/rest home has a large open-plan dining area with kitchenette and lounge area. On one side is a spacious lounge and the other side is the dining area. There is another smaller quieter lounge/library located off the main lounge. The open plan lounge is large enough for individual or group activities. All serviced apartments also have their own spacious lounge and kitchenette.</p> <p>Each dementia unit has an open-plan living area. Each living area is spacious with a separate dining area. The spacious open plan area allows for quiet areas and group activities. The hallways and communal areas allow maximum freedom of movement while promoting the safety of residents who are likely to wander. There is a second quiet lounge in each of the units and an interactive lounge at the end of the wings. There is free access to the safe outdoor gardens and walking pathways. There is a secure connecting door between the units that can be opened up for entertainment and larger group activities.</p> <p>The fifth level is the village centre with communal areas available to care centre residents including the café, library, movie and craft room.</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>The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The laundry is located in the service area adjacent to level 2. The laundry has a double door and has an entry and exit with defined clean/dirty areas. All linen and personal clothing is laundered on site. There are two laundry staff seven days a week (one from 8 am-4.30 pm and one from 10 am-4 pm). All laundry is sorted prior to washing. There are large commercial washing machines, sluice machine and dryers. There is a large folding table and laundry is placed into a delivery trolley for distribution to resident rooms. The service has a secure area for the storage of cleaning and laundry chemicals in the laundry. Material safety datasheets are readily accessible.</p>

		<p>Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Cleaners' trolleys (sighted) were well equipped and had a locked chemical box. All chemical bottles have the correct manufacturer's labels. Cleaners' trolleys are kept in locked cupboards when not in use.</p> <p>Residents interviewed stated they are happy with the cleanliness of their bedrooms and communal areas. Other feedback is received through resident meetings and results of internal audits. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a minimum of one first aid trained staff member on every shift. The care centre has an approved fire evacuation plan and fire drills take place six monthly at a minimum. Smoke alarms, sprinkler system and exit signs are in place. The service has emergency generators on site that are serviced by an external contractor. There are gas BBQs available in the event of a power failure and torches. Emergency lighting is in place, which will last for four hours. There are civil defence kits in each unit and adequate stores of drinkable and non-drinkable water on site.</p> <p>The call bell system is available in each resident room. There are call bells and emergency bells in communal 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 cascades if not responded to within a certain time from the primary nurse (caregiver) to the unit coordinator, to the clinical manager and to the village manager. The system software is monitored. In the dementia unit, the system includes an electronic beam management technology which is used to alert staff on the movements of residents in their rooms who are at high risk of falling. Alerts are sent electronically to staff for those high-risk residents who are attempting to get out of bed unsupervised. Once the resident gets out of bed at night the ensuite light automatically comes on. Residents are also issued with call bell pendants for those who are able to use them.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is under-floor heating throughout the facility and air conditioning in communal areas. All rooms have external windows with plenty of natural sunlight.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. Infection control across the facility is a shared responsibility between the clinical manager and hospital unit coordinator. Job descriptions outline the role and responsibilities. The infection prevention and control committee meet two monthly and comprise of a cross section of staff. The infection control coordinators provide monthly reports to head office and to the full facility meetings.</p> <p>The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually, and a six-month analysis is completed by the infection control coordinators and reported to the governing body.</p> <p>All visitors and contractors are required to complete an electronic health declaration which also serves as contact tracing. Residents and staff are offered the annual influenza vaccine. All staff are now required to have an influenza vaccine prior to commencing work at Ryman as part of the Ryman initiative against Covid 19. Residents transferring from hospital or the community are placed in isolation for 14 days. There are adequate hand sanitisers and signage throughout the facility. There is an outbreak management bin and plentiful stock of personal protective equipment that is checked weekly.</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 control coordinators completed the infection control induction on appointment to the roles and attended an annual external education programme (March 2020) with a microbiologist via teleconferencing.</p> <p>The facility has 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</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 developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. There is resource information and plans around Covid 19.</p>

<p>in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinators are responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions, and training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits six monthly. In-services have been provided around personal protective equipment and outbreak management. Infection control is an agenda item on the full facility and clinical meeting agenda. An additional competency has been added to the training schedule on personal protective equipment. Staff are also required to complete a self-directed or on site session on Covid 19.</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 Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance 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 for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection prevention coordinators complete a monthly report. Monthly data is reported to the infection control committee and meeting minutes are available to staff. Staff are informed of surveillance through the variety of clinical meetings held at the facility. 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. Benchmarking against other Ryman facilities occur. Quality improvements are commenced for any areas identified for improvement. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>The clinical manager is the restraint coordinator. On interview he confirmed his knowledge around both restraints and enablers. During the audit, there were no residents using any restraints or enablers.</p>

		Staff training including staff competencies are implemented addressing restraint minimisation and enablers, falls prevention and analysis, and the management of challenging behaviours. This begins during their induction to the service and continues annually.
--	--	--

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Monitoring forms reviewed on the electronic work logs included blood pressure, weight, blood sugar levels, pain, behaviour, repositioning charts, food and fluids, intentional rounding, and neurological observations, however not all neurological observations had been completed as per protocol.	Four of six residents' electronic progress notes for those residents who experienced an unwitnessed fall failed to indicate the timeliness for initiating and continuing to complete neurological observations as per the falls protocol. Neurological observations for these four residents were documented as being initiated one – two hours after the fall and ongoing neurological observations were occasionally recorded within one minute of each other. The clinical manager reported that this was an issue with the electronic system and that he believed neurological observations were being done by the nursing staff in a timely manner.	<p>Ensure the electronic system used to record neurological observations reflect the actual time(s) of neurological observations as per protocol for unwitnessed falls.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.