

# Kiri Te Kanawa Retirement Village Limited - Kiri Te Kanawa Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Kiri Te Kanawa Retirement Village Limited
<b>Premises audited:</b>	Kiri Te Kanawa Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 2 August 2021 End date: 3 August 2021
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	104



# Executive summary of the audit

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## 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

Ryman Kiri Te Kanawa provides rest home, hospital and dementia level of care for up to 127 residents. There were 104 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, relatives, management, staff and the nurse practitioner.

Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually and have been fully implemented.

At the time of the audit there was a relieving village manager. A new village manager has been appointed and her first day in the role was during the audit. The village manager is supported by a clinical manager who has been in the role since March 2020 and an assistant to the manager.

This certification audit did not identify any areas for improvement.

There are two areas of continuous improvement awarded around the fall's prevention programme and activities programme.

## 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.
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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 can visit residents at times that meet their needs. There is an established system 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.
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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 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. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service

education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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There is an information package for residents/whanau on admission to the service including a brochure specifically relating to the special care (dementia) unit. Registered nurses are responsible for each stage of service provision including assessments, risk assessments, care plans and evaluations, which are updated at least six-monthly. Care plans demonstrate service integration and the residents/family interviewed confirmed they were involved in both the initial care planning process and ongoing review. Resident files include medical notes by the contracted general practitioner (GP), nurse practitioner (NP) and visiting allied health professionals. The general practitioner completes an admission visit and reviews the residents at least three-monthly. Medication policies and processes reflect legislative requirements and guidelines.

Registered nurses and senior caregivers are responsible for the administration of medicines and have completed annual competencies and education. Medication charts are reviewed three-monthly by the GP/NP. The activity team provides an activities programme which is varied and interesting for each resident group. The engage programme meets the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links and there are regular entertainers, outings, and celebrations. The menu is designed by a dietitian at an organisational level. All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were satisfied with the meals and commented positively when interviewed. There are snacks available at all times.

## 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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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. All bedrooms have ensembles, additionally there are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility with hallways and communal areas being spacious and accessible. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available. There are policies, systems and supplies in place for essential, emergency and security services, including adequate civil defence/emergency water stocks. First aid trained staff members are on duty at all times. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site. Both departments have appropriate policies and product safety charts in place and quality standards are monitored through the internal auditing system. Chemicals are stored safely throughout the facility. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management training.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There was one resident with a restraint and two residents with enablers during the audit. Staff receive training around restraint minimisation and the management of challenging behaviour.

## Infection prevention and control

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

Standards applicable to this service fully attained.

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 prevention and control leader (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control lead has attended external training. The infection control manual outlines a range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control lead 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)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	2	99	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one relieving village manager, one clinical manager and one regional operations manager) and nineteen care staff; six registered nurses (RNs) including two-unit coordinators, nine caregivers including two rest home, three hospital, two dementia and two serviced apartments and four activities staff described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training 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 resuscitation and general consent forms were evident in all eleven resident files reviewed: four rest home (including one serviced apartment, one ACC and one respite), five hospital and two dementia. 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. All files of residents reviewed in the special care (dementia) unit had activated EPOA's.</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	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 the resident's family/whānau and chosen social networks.
<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	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. 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>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with residents and relatives, confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint's 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. Three complaints received in 2021 (year to date) and two complaints made in 2020 have been managed in a timely manner and are documented as resolved.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Eight relatives (three rest home, three hospital and two dementia care) and seven residents (five rest home and two hospital care) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The relieving village manager and clinical reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope.

<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>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. Residents' 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 resident cares. Staff attend education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has links with the local district health board (DHB) for advice and support as required. There were four residents who identified as Māori at the time of the audit. Cultural needs were addressed in two resident's care plans reviewed.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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 multidisciplinary 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. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial,</p>	FA	<p>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.</p>

or other exploitation.		
<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. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (formerly known as 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.</p> <p>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 system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to practice based on the evidence provided. The service has been awarded a continuous improvement around the activities programme.</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>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 and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is 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 care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. Fifteen incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed, for residents who are unable to speak or understand English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>Kiri Te Kanawa is a Ryman Healthcare retirement village located in Gisborne. They are certified to provide rest home, hospital (geriatric and medical) and dementia levels of care in their care centre for up to 97 residents. In addition, there are 30 serviced apartments that are certified to provide rest home level care. In the care centre, there are 81 dual-purpose (rest home/hospital) beds and 16 beds in the secure unit for</p>

<p>appropriate to the needs of consumers.</p>		<p>dementia level of care.</p> <p>Occupancy in the care facility during the audit was 40 rest home, 39 hospital and 16 dementia level residents. In addition, there were nine rest home level residents in the serviced apartments. There was one rest home level resident on respite and one rest home level resident on an ACC contract. The remaining residents were on an aged residential care contract (ARCC).</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Four village objectives for 2021 (increase resident engagement, Covid-19 staff vaccination, mastering ChattR and improving resident falls rate) are defined with evidence of reviews in April 2021 on progress towards meeting these objectives. Objectives and the progress towards meeting these objectives are posted in the staff room.</p> <p>At the time of the audit there was a relieving village manager, who manages another Ryman retirement village. A new village manager has been appointed and her first day in the role was during the audit. The village manager is supported by a regional manager, an assistant to the manager and a clinical manager. The clinical manager is an experienced RN who has been in her role since March 2020.</p> <p>The relieving village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.</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>	<p>FA</p>	<p>The clinical manager is responsible during the temporary absence of the village manager, with support from the assistant to the manager, regional operations manager and Ryman management team.</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</p>	<p>FA</p>	<p>Ryman Kiri Te Kanawa has a well-established quality and risk management programme that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings (teamRyman, full facility, clinical, health and safety infection control meetings) and reported to the organisation's management team. Discussions with the management team and staff, and review of meeting minutes demonstrated their involvement in quality and risk activities. Annual resident and relative surveys are completed. Results and any areas for improvement are fed back to staff and participants through resident (two-monthly) and relative (six-monthly) meetings. The resident's overall satisfaction average score was</p>

improvement principles.		<p>4.42 and the relatives' overall satisfaction rate was 4.37. Corrective actions have been established around food satisfaction, housekeeping and activities.</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 and Disability Services (Safety) Act 2001. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the combined monthly health and safety and infection control meetings. The staff health and safety officer (receptionist) was interviewed. She has completed level two external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of the risk register indicated that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place that include ongoing falls assessment, reviewing call bell response times and routine checks of all residents specific to each resident's needs. All falls are fully investigated, medical causes identified and treated, location and timing of falls analysed for trends and ongoing education includes manual handling, hoist refreshers, intentional rounding and use of equipment such as sensor mats, physiotherapy input and encouragement in exercise programmes. Case studies are discussed at clinical meetings. General practitioners (GP) are notified of falls and a medical review including medication review is completed. Care plans record falls prevention strategies that reflect the residents falls risk. Falls prevention and management training has been held at a full facility meeting in April 2021 for all staff to attend.</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</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. A review of a sample of 15 incident/accident forms for June and July 2021 identified that all are fully completed and include follow-up by a RN. Neurological observations are completed if there is a suspected injury to the head. The clinical manager is involved in the adverse event process with links</p>

<p>affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>to the regular management meetings and informal meetings. This provides the opportunity to review incidents as they occur.</p> <p>The relieving village manager and clinical manager were able to identify situations that would be reported to statutory authorities. This included completing section 31 reports (one unstageable and one stage 3 pressure injury, one resident absconding and one recent police investigation, which is still ongoing) and notifying public health for one outbreak since the previous audit.</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 human resources policies including recruitment, selection, orientation and staff training and development. Twelve staff files reviewed (one clinical manager, three-unit coordinators, one RN, five caregivers, one activities coordinator and one chef) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN, EN and health professional practising certificates are maintained and current. An orientation/induction programme provides new staff with relevant information for safe work practice. There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies.</p> <p>There is a completed annual education plan for 2020 and the plan for 2021 is being implemented. The annual training programme exceeds eight hours annually. Additional toolbox sessions are provided. Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session. Staff are also required to complete a series of comprehension surveys each year. There are 19 RNs working at Ryman Kiri Te Kanawa and nine have completed interRAI training. There are 71 caregivers in total. Completed Careerforce training as follows; 23 have completed level four, 29 have completed level three and one has completed level two training. Seven of twelve caregivers who work in the dementia unit have completed their dementia qualification. Five are in progress of completing and have been employed for less than 18 months.</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 facility covers three floors with elevators in strategic locations. The clinical manager is an experienced RN who works full time from Sunday to Thursday.</p> <p>One the ground floor (first level) there were 39 hospital and 28 rest home residents (69 beds). Staffing includes a unit coordinator/RN (Tuesday to Saturday). Three RNs cover the morning shift, and two RNs cover the afternoon shift. The night shift is staffed with one RN. (Note: an additional RN is rostered over the two days that the unit coordinator is not rostered). Eight caregivers are rostered on the morning shift</p>



		<p>(three long and five short) and seven are rostered on the afternoon shift (two long and five short). The night shift is staffed with two (long shift) caregivers. One fluid assistant covers from 9.30am to 4.00pm and a lounge carer assists from 4.00pm to 8.00pm.</p> <p>On the second level there were 16 dementia level residents (16 beds) in the secure dementia unit and 12 rest home residents (12 beds). A unit coordinator/RN covers the dementia unit and the rest home residents from Sunday to Thursday. An RN covers on the two days that the unit coordinator is not available. The dementia unit is staffed with two caregivers on the morning and afternoon shifts (one long and one short) and one caregiver on the night shift. rest home level residents were on the second level. There is one caregiver on the morning, afternoon and night shift covering the rest home level residents on the second level.</p> <p>There are thirty serviced apartments certified to provide rest home level of care that cover two floors (second and third levels). There were nine rest home level residents in the serviced apartments at the time of the audit. The serviced apartment coordinator is an enrolled nurse (EN) who works Sunday to Thursday. An RN covers in her absence (Friday and Saturday). There are three caregivers on the morning shift (one long and two short) and two on the afternoon shifts (one works until 7.00pm and one works until 9.00pm). The after 9.00pm and night shift is covered by a caregiver in the rest home. Staff communicate via mobile telecommunications.</p> <p>Extra staff can be called on for increased resident requirements. A cover pool has been implemented whereby (extra) care staff are scheduled to work Friday to Monday to cover absences. Additional casual staff are available if needed.</p> <p>Activities staff are scheduled seven days a week in the hospital and dementia units and five days a week in the rest home and serviced apartments. Separate cleaning and laundry staff are rostered seven days a week.</p> <p>Staff were visible and were attending to call bells in a timely manner as observed by the auditors and 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,</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. 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.</p>

confidential, and accessible when required.		
<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. The service has an information pack available for residents/families at entry including information on the 48-hour complimentary service for village residents, short-term stays, rest home, hospital, and dementia level of care services. 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 and the two short stay admission agreements for a respite and ACC care resident 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>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. One resident file sampled evidenced a transfer to public hospital post fall and subsequent return. A record of transfer documentation was kept on the resident's file. All relevant information was documented and communicated to the receiving health provider or service. Communication with family occurred in a timely and appropriate manner.</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 all aspects of medication management, including self-administration. Registered nurses, enrolled nurses and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (hospital unit, rest home, serviced apartments and dementia care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk imprest supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication rooms and fridges are checked daily, and temperatures sighted were within the acceptable range.</p> <p>There were six rest home residents (including three serviced apartments) and one hospital level resident self-medicating on the day of audit. Medications were stored safely in the resident's room. Three monthly self-medication competencies had been completed by the RN and authorised by the GP/NP. There were no standing orders. There were no vaccines stored on site. Twenty-two medication charts on the electronic medication system were reviewed (ten hospital, eight rest home and four dementia care). Medications are reviewed at least three-monthly by the GP/NP. The GP/NP and the mental health service for older adult's review 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. Medication administration</p>

		observed complied with policy.
<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>The meals at Ryman Kiri Te Kanawa are all prepared and cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, which expires 9 May 2022. There is a four weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The chefs (one lead chef) interviewed were aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. The service utilises pre-moulded pureed foods for those residents requiring that particular modification. Residents have access to nutritious snacks 24 hours a day.</p> <p>On the day of audit, meals were observed to be well presented. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. The residents interviewed were very complimentary regarding the standard of food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</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 Consumers' needs, support requirements, and preferences are gathered and</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. Initial assessments had been completed on the myRyman system within 24 to 48 hours of admission for all residents entering the service including the respite and ACC residents. InterRAI assessments had been completed in all long-term residents' files</p>

recorded in a timely manner.		reviewed. Applicable assessments are completed and reviewed at least six-monthly or when there is a change to residents' health. The outcome of all assessments is reflected in the myRyman care plan.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of 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, resident goals and provide detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. MyRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, occupational therapist, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access.</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>	FA	<p>When a resident's condition changes the RN initiates a GP/NP or nurse specialist consultation. RNs interviewed stated that they notify family members about any changes in their relatives' health status. Family members interviewed confirmed this. Conversations and notifications are recorded in the electronic progress notes. All care plans reviewed had interventions to meet the needs of the resident. Care plans have been updated as residents' needs changed. The electronic myRyman 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's room allows the caregiver to sign the task has been completed (e.g., resident turned, fluids given).</p> <p>Care staff interviewed stated there are adequate supplies and equipment provided including continence and wound care supplies. Wound assessment and management plans are completed on myRyman. When wounds are due to be dressed, a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms and wound monitoring occurred as planned in the sample of wounds reviewed. There are currently two lesions, twelve skin tears (six for one resident), two chronic ulcers, one surgical and three classed as other. There is one stage 2 pressure injury (facility acquired) which has been reviewed by the wound nurse specialist and wound champion.</p> <p>The wound champion nurse reviews all wounds at least monthly in addition to ongoing review by the RN on duty. Pressure injury prevention equipment is available and being used. Caregiver's document change of position electronically. Short-term care plans are generated through completing an updated assessment on myRyman and interventions are automatically updated into care plans. Evaluation of the assessment when resolved closes out the short-term care plan. Electronic monitoring forms are in use as applicable such as:</p>

		weight; food and fluid; vital signs; blood sugar levels; neurological observations; wound monitoring; and behaviour charts. The RNs review the monitoring charts daily.
<p><b>Standard 1.3.7: Planned Activities</b></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>	CI	<p>A team of seven activity and lifestyle coordinators implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The programme is overseen by a group diversional therapist at Ryman head office. The rest home programme is Monday to Friday, the hospital unit and the special care dementia unit is seven days a week.</p> <p>There is a monthly programme for each unit, delivered to each resident's room. A daily activity programme is written on the lounge whiteboard. Residents have the choice of a variety of Engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home resident in the serviced apartment can choose to attend the serviced apartment or rest home activity programme. 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. The village has a wheelchair accessible van available for the twice weekly outings and has a driver on staff available as required. There are regular combined activities and celebrations held in the ground floor village lounges for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision in addition to those activities held in the special care unit.</p> <p>Activities in the special care unit include triple A exercises, singing, happy hours, hand therapy, word games, make and take and game competition. The men attend the combined units' men's group for activities and outings. An activity and lifestyle coordinator is on duty eight hours a day, seven days a week. Kindergarten groups and pet therapy visits occur in all units. The service also holds weekly Te Reo classes for any resident wishing to attend. During Covid-19 lockdown, the service-initiated hallway activities in all units, with coordinators providing entertainment, hosting quizzes and facilitating exercise sessions for residents who were unable to leave their room. Happy hour supplies were delivered to individual rooms and entertainment provided via the tablet situated in each resident's room. The service also activated zoom sessions for all residents to maintain communication with families, which was managed on a day-to-day basis by the activities team. There are various denominational church services held in the care facility weekly. There are regular entertainers visiting the facility. Special events like birthdays, St Patricks day, Matariki, Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated.</p> <p>Residents have an activity assessment (life experiences) 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. Residents have the opportunity to provide feedback though resident and relative meetings</p>

		and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All of the nine long-term resident care plans reviewed had been evaluated by the RNs six monthly or when changes to care occurs. The RN completes a daily evaluation for the ACC and short-term respite resident. The multidisciplinary review involves the RN, GP/NP, caregiver and resident/family if they wish to attend, resident progress towards meeting goals are discussed and documented. The hospice nurse (interviewed) also stated she was invited to attend if appropriate. Activities plans are evaluated at the same time as the care plan. There are one to three monthly reviews by the GP/NP for all residents. Family members interviewed confirmed that they are consulted/informed regarding any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	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, geriatrician, mental health services for older people, and dietitian. Discussion with the RNs identified that the service has access to a wide range of support either through the GP/NP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's 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. A spills kit is available.
Standard 1.4.2: Facility Specifications	FA	The building has a warrant of fitness that expires 1 July 2022. The facility employs a full-time maintenance officer (interviewed) who is a qualified electrician, gardens and grounds staff. Daily maintenance requests

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>are addressed, and a 12-monthly planned maintenance schedule is in place and has been signed off monthly (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment. This is next due September 2021.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. The facility has wide corridors with sufficient space for residents to mobilise safely using mobility aids. Residents were observed safely accessing the outdoor gardens and courtyards. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans. The dementia unit on the second floor has an outdoor balcony deck with raised gardens, seating and shade.</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>	FA	<p>All rooms within the facility 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 mobility toilets near all communal lounges. There are privacy signs on all toilet doors.</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>	FA	<p>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 can personalise their rooms and the rooms are large enough for family and friends to socialise with the resident.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	FA	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are dining rooms in each area. The dementia unit has a separate dining room and main lounge with a smaller quiet sensory lounge. There is a, café, and hairdressing salon.</p>

safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>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 datasheets. Personal protective equipment is available. The two laundry assistants interviewed were knowledgeable around infection control practices and laundry processes. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaners’ trolley sighted were labelled. 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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Staff have attended emergency and disaster management training. The facility has an approved fire evacuation scheme in place, letter dated 16 April 2021. Fire evacuation drills take place six-monthly. The last fire evacuation drill occurred on 29 April 2021. Smoke alarms, sprinkler system and exit signs are in place. There are staff employed across the facility 24/7 with a current first aid certificate. There are first aid kits located at reception, kitchen, facility van and nurses’ hubs. Battery operated emergency lighting is in place which runs for at least four hours. The facility has an on-site diesel generator to run essential services.</p> <p>There is a civil defence kit located on each level which are checked three-monthly. Supplies of stored drinkable water is stored in large holding tanks (six 1,000 litre header tanks). There is sufficient water stored to ensure 10 litres per day for seven days per resident. There are alternative cooking facilities available with a gas barbeques and gas Hobbs in the kitchen. There is an effective call bell system in all bedrooms, ensuites and communal areas. The call bells and door alarms are linked to pagers carried by staff. Calls light up on the main call panel in the nurse’s station. Staff advise that they conduct security checks at night, in addition to an external contractor. A security camera is installed at the entrance. The facility is secure after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. Heating is a mixture of underfloor, wall heaters and individual heat pumps, all of which are thermostatically controlled. Staff and residents interviewed stated that these are effective. The entire site is smoke free.</p>



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 is appropriate for the size and complexity of the service. The infection prevention and control leader (RN) has a job description which defines the role and responsibilities for infection control. The infection prevention and control committee meet bi-monthly, and the programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection prevention and control leaders. Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents have received both doses of the Pfizer Covid-19 vaccine (90%) with staff vaccination ongoing in conjunction with the local DHB. Residents and staff are offered the influenza vaccine.</p> <p>There has been one outbreak (respiratory) in 2020 which was appropriately managed and included liaison with the local DHB and public health unit. Covid-19 education has been provided for all staff, including hand hygiene and use of PPE. During Covid-19 lockdown it was mandatory for staff not to travel to and from the facility in uniform, with changing facilities provided on site. Although this is no longer mandatory, it is strongly encouraged as being best practice. Ryman has a dedicated infection control channel on the ChattR app for information, education and discussion and Covid updates should matters arise in between scheduled meeting times. All visitors are required to provide contact tracing information.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Ryman Kiri Te Kanawa. The infection control committee meet two monthly, with information then being cascaded as part of staff meetings and also as part of the RN meetings. The infection prevention and control leader has completed training in infection control. The infection prevention and control leader has access to an infection prevention and control nurse specialist from the DHB, 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</p>	FA	<p>There are 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 control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection prevention and control leader 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.
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.	FA	The surveillance programme is organised and promoted via the Ryman calendar. Effective monitoring is the responsibility of the infection prevention and control leader (RN). An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the clinical meeting, weekly management meeting, infection prevention and control (IPC) meetings and full staff meetings.  Six-monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Ryman Kiri Te Kanawa include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation and are analysed at site level using power BI. There has been one outbreak in October 2020 which was appropriately managed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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. At the time of the audit there was one hospital resident with a restraint (bed rail) and two hospital residents using enablers (bed rails). The two resident files were reviewed where an enabler was in use. Voluntary consent and an assessment process had been completed. The enabler is linked to the resident's care plan and is regularly reviewed. Staff receive training

		around restraint minimisation and the management of challenging behaviour.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (hospital unit coordinator) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The approval group meets six-monthly, and all restraint and enablers are reported to teamRyman monthly.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The file of the hospital resident using restraint was reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the resident file reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures. A restraint register is in place providing a record of restraint and enabler use. This is completed for all residents requiring restraints and enabler.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all</p>	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in the resident file reviewed where restraint was in use.

episodes of restraint.		
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme.</p>

## Specific results for criterion where corrective actions are required

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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
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## 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 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks</p>	CI	<p>Robust systems are in place for the collection, analyses, and evaluations of quality data. A range of data is collected around falls, skin tears, pressure injuries, and infections across the service through myRyman. Data collated is used to identify any areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management, full facility and clinical/RN meetings). Templates for all meetings document action required, timeframe, and the</p>	<p>Falls in the dementia unit were identified as an area that required improvement from data collected from 2019. A continuous improvement plan was developed in April 2020 which included identifying residents at risk of falling, reviewing call bell response times, routine checks of all residents specific to each resident’s needs, hourly intentional rounding for identified high risk fallers, reviewing the roster to ensure adequate supervision of residents, the use of sensor mats and night lights, proactive and early GP involvement for residents post falls and review of underlying causes for falls including medications, and increased staff awareness of residents who are at risk of falling.</p> <p>The plan has been reviewed monthly and discussed at leadership, staff and clinical meetings. Education and training for staff has been provided on manual handling, safe transfers, hoisting, safe use of equipment, uses of sensors and devices, managing distressed behaviour and promoting</p>

<p>associated with service provision is developed and implemented.</p>		<p>status of the actions.</p> <p>Falls are discussed at the leadership meetings, with fall prevention strategies reviewed, and the residents underlying conditions considered. The falls assessment tool is completed, and falls protocols are monitored and followed up post falls. The clinical manager reviews the call bell report daily, and copies are provided to the unit coordinators. The physiotherapist review changes in resident mobility and a lounge carer is in the lounge monitoring residents. Residents at risk of falling are encouraged to join the exercise programme. Falls and incidents are discussed at the handovers between shifts to ensure staff are up to date with current information.</p>	<p>nutrition/hydration. Caregivers interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The outcome of the plan has been that falls rates in April 2020 were at 10.17/1000 occupied bed nights, the rate of falls continued to reduce with the rates in April 2021 being at 4.35/1000 occupied bed nights.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>All residents are assessed at admission and in an ongoing manner to establish interests and skills and an activity plan is developed for the residents around activities. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. The activity programme was reviewed and adapted to continue the provision of engaging residents in meaningful activities during a period of pandemic lockdown restrictions. This resulted in continued resident engagement, physical activity, social interaction and resident satisfaction.</p>	<p>The resident survey results in February 2020 had a score of 4.08. A continuous improvement plan was developed. Due to pandemic restrictions in parts of 2020, residents were unable to attend group activities and at times were unable to socialise with other residents and/or have visitors. Despite the lockdown, the activities team adapted the programme to enable resident participation in virtual groups through the use of technology and the provision of remote activity facilitation, including virtual happy hour, zoom platform sessions including exercises, video call, etc and the maintenance of contact with family and friends. This resulted in an improved resident satisfaction survey result, related to activities of 4.20 in February 2021. Interviews with residents during the audit confirmed their satisfaction and engagement with the activities team and programme. Residents also stated that they felt they had improved social interaction, level of engagement and enjoyment of their activities during this</p>

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End of the report.