

Ernest Rutherford Retirement Village Limited - Ernest Rutherford 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Ernest Rutherford Retirement Village Limited
Premises audited:	Ernest Rutherford 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: 11 October 2021 End date: 12 October 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	95



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

Ryman Ernest Rutherford provides rest home, hospital, and dementia level of care for up to 124 residents. There were 95 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 general 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.

The village manager has been in the role since January 2021. The village manager is supported by a clinical manager who has been in the role for three and a half years and an assistant to the manager.

This certification audit did not identify any areas for improvement.

Areas of continuous improvement have been awarded around the fall's prevention in the special care unit, prevention of pressure injuries, the activity programme, food services, and low incidence of infection.

Consumer rights

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

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

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm 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. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

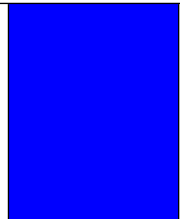
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. They are supported by three-unit coordinators/registered nurses. Goals are documented for the service with evidence of regular reviews. Comprehensive quality and risk management programmes are being implemented. Corrective actions are implemented 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 implemented for new staff. Ongoing education and training cover in-service education, external training and competency assessments. Registered nursing cover is provided 24/7. Residents and families report 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/relatives on admission to the service. The registered nurses' complete assessments, care plans and evaluations within the required timeframe. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner or nurse practitioner completes admission visits and reviews the residents at least three-monthly.

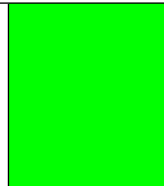
The activity team provides an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The Engage programme meets the abilities and recreational needs of the groups of residents. The programme is varied and involves community visitors. There were individualised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

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

The project delicious menu is designed by a dietitian at an organisational level. All baking and meals are cooked on site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24-hours in the special care (dementia) unit.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

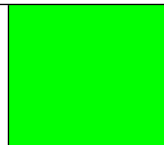


Standards applicable to this service fully attained.

Chemicals were stored safely throughout the facility. There is a preventative and planned maintenance schedule in place. The building has a current warrant of fitness. There was sufficient space to allow the movement of residents around the facility. The communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. All bedrooms are single occupancy with ensuites. There are policies in place for emergency management. There is an approved fire evacuation scheme, six-monthly fire drills have been performed. Staff have attended emergency and disaster management. There is a first aider on-site at all times. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on site.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were two residents using restraints and no residents using enablers at the time of the audit. Staff receive training around restraint minimisation.

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.

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

The infection prevention and control programme include policies and procedures to guide staff. The infection prevention and control meeting is held two monthly. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. Staff have completed training around infection control and Covid19.

Covid is well prepared for. All visitors and contractors are required to complete a wellness declaration, use hand sanitisers and wear a mask in line with current Covid 19 guidelines. Adequate supplies of personal protective equipment were sighted during the audit. The recent outbreak was well documented and managed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	3	47	0	0	0	0	0
Criteria	5	96	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Two managers (one village manager, one clinical manager) and twenty-eight staff (twelve registered nurses (RNs) including three unit coordinators and nine staff RNs; eight caregivers (two hospital, two dementia, two service apartments, two rest home) who work across the AM and PM shifts; one assistant to the manager; four activities coordinators; one chef; one housekeeper; one laundry assistant) confirmed their understanding of the Code and its application to their specific job role and responsibilities. Staff receive training about the Code, which begins during their induction to the service. This training continues through the mandatory staff education and training programme, which includes competency questionnaires.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents are signed for by the resident or their activated enduring power of attorney (EPOA). Consents are signed (sighted) for specific procedures such as restraint and influenza and covid19 vaccines. Advanced directives where available are kept in the resident files. Resuscitation status is made by the competent resident. There is evidence of discussion with the resident and family when the GP completes a clinically indicated not for resuscitation order for residents deemed to be incompetent. Caregivers and registered nurses interviewed</p>

<p>information they need to make informed choices and give informed consent.</p>		<p>confirmed verbal consent is obtained when delivering care. Discussion with relatives identified that the service actively involves them in decisions that affect their relative's lives. Three dementia care resident files identified the EPOA had been activated.</p> <p>Ten resident files reviewed (three dementia, four hospital and three rest home residents) have signed admission agreements.</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>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides 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. Information is available on notice boards regarding HDC advocacy services. Interviews with managers and care staff supports the caregiver's role as advocates for the residents.</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>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include 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. Residents are encouraged to integrate into village activities. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy is being implemented. The village manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. The village manager maintains an up-to-date complaints' register. Concerns and complaints are discussed at relevant meetings. No complaints have been lodged through HDC or the DHB since the previous audit.</p> <p>Eight complaints have been lodged in 2021 (year to date) (three verbal and five written). Three complaints were unsubstantiated. Two complaints were reviewed in detail. Acknowledgement of the lodged complaints and an investigation and communication with the complainants were included in the register. All substantiated complaints are documented as resolved.</p> <p>Interviews with residents and relatives confirmed they were provided with information on the complaints process.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Nine relatives (five hospital, one rest home and three dementia) and five residents (three rest home and two hospital) stated they were provided with information on admission, which includes information about the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager confirmed his office, located at the entrance to the village, is open to visitors. Relatives and residents are informed of the scope of services and any liability for payment for 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>Ryman policies that support resident privacy and confidentiality are being implemented. 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 are closed while care is being undertaken. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences including cultural, religious, social and ethnic are identified during the admission and care planning process with evidence of family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings. Caregivers interviewed described how choice is incorporated into resident cares. There are policies, procedures and training in place that address elder 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>There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Manākitanga is strong and embedded at Ernest Rutherford and reflects the key values of kindness, caring and compassion and sees a strong sense of belonging, and of community. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The village manager identifies as Māori with links to Tainui and Ngāti Maniapoto. Links are being established with Ngait Koata and Te Tau Ihu. The village manager is investigating the story behind a korowai that was gifted to the facility and is displayed in the foyer.</p> <p>There were two Māori residents at the time of the audit. Both residents have detailed cultural values and beliefs described in their care plans and activity plans. Neither resident nor their whanau were available to be interviewed. An example was provided by staff whereby reciting karakia assists in calming a Māori resident.</p>
<p>Standard 1.1.6: Recognition And Respect</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-</p>

<p>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>		<p>monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that the 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, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. All staff are required to read and sign the Ryman professional boundaries policy as part of the new employee induction process. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Managers provide guidelines and mentoring for specific situations. Interviews with 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>	<p>CI</p>	<p>All Ryman facilities have a master copy of policies, which are 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 range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch 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. There have been no pressure injuries for the past year, resulting in a rating of continuous improvement. A reduction of falls in the dementia unit has also resulted in a rating of continuous improvement (link CI 1.2.3.6). Feedback is provided to staff via the various meetings as determined by the team Ryman programme. Corrective action reports are implemented where results do not meet expectations or non-conformances are identified.</p> <p>An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. A physiotherapist is available nine hours per week and is assisted by a physiotherapy assistant (five days a week). A number of general practitioners (GPs) and a nurse practitioner (NP) from the local community visit the facility throughout the week with on-call service provided by the Nelson after hours clinic.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Fifteen assessment forms reviewed that are completed following an</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>adverse event evidenced that family are kept informed. Relatives interviewed confirmed that they are informed when their family member's health status changes and/or if there has been an adverse event. Extra efforts have been implemented to maintain communication between residents and their families during periods of lockdown during the Covid pandemic with scheduled zoom meetings encouraged.</p> <p>Residents' meetings occur two monthly and family meetings take place six-monthly.</p> <p>Residents and families interviewed confirmed they are welcomed on entry and are given time and explanation about the services and procedures. Specific and written information is provided to families about the unique aspects of the dementia unit. 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>Interpreter policy and contact details of interpreters is available. During the audit there was one resident who has difficulty communicating in English, often reverting to their native language. The care staff are able to communicate effectively with this resident through sign and body language.</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>	<p>FA</p>	<p>Ernest Rutherford is a Ryman Healthcare retirement village. They are certified to provide rest home, hospital (medical and geriatric) and dementia levels of care in their care centre for up to 124 residents including 30 serviced apartments that are certified to provide rest home level care. Sixty-nine beds in the care centre are certified as dual-purpose beds and twenty-five beds are available in the special care unit for dementia level of care.</p> <p>Occupancy in the care centre was 24 residents at rest home level of care: 37 residents at hospital level care and 23 residents at dementia level care. There were ten rest home level residents in the serviced apartments. The hospital level of care is certified for geriatric and medical. All residents were under the age-related residential care agreement.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Annual objectives are defined with evidence of monthly reviews and quarterly reporting to Ryman Christchurch on progress towards meeting these objectives. Staff are kept informed of progress in the full facility meetings.</p> <p>The village manager (non-clinical) was appointed in January 2021 and is new to aged care management. He has 31 years of experience in facility management, including holding a senior leadership role for over 15 years as a general manager. He has undergone an extensive orientation programme relating to managing an aged care retirement village, which included shadowing an experienced village manager for one week. The village manager is supported by a regional manager, an assistant to the manager and a clinical manager/RN. The clinical manager has 27 years of clinical experience and ten years of management experience. She has worked at Ryman Ernest Rutherford for over three years. Both managers have attended over eight hours of professional development relating to their respective roles in aged care.</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 clinical manager (RN) is second in charge during the temporary absence of the village manager with support from the regional manager and Ryman management team. Three-unit coordinators/RNs (hospital, dementia, serviced apartments) are responsible for clinical operations in the 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>The Ryman quality and risk management systems are fully implemented. Quality data and outcomes are reported across the various meetings, including the monthly full facility, and RN/clinical meetings. Meeting minutes include discussions relating to the key components of the quality programme including (but not limited to) policy updates, internal audit results, training scheduled, complaints received, accidents/incidents, infection control data and corrective actions. Interviews with staff confirmed their understanding of the quality and risk management programmes.</p> <p>Policy review is coordinated by Ryman Christchurch (head office). Policy documents are developed in line with current best and/or evidenced based practice. Staff are informed of changes/updates to policy at relevant staff meetings. In addition, a number of core clinical practices include staff comprehension surveys that staff are required to complete to evidence competency. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room. Staff are required to read and sign that they have read the meeting minutes, which includes policy updates.</p> <p>Relative and resident surveys are completed annually with the relative survey taking place at the time of the audit. Results are collated with annual comparisons for each service. Corrective actions are implemented if scores indicate improvements are required. Residents and families are kept informed via residents' meetings and six-monthly relative meetings. Staff are informed in the monthly staff meetings.</p> <p>An annual internal audit schedule is being implemented. Internal audit summaries and corrective actions are completed where a non-compliance is identified (<90%). All corrective actions are listed in a corrective action report register and are regularly updated, evidenced in meeting minutes.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of corrective actions when volumes exceed targets. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A reduction in falls in the</p>

		<p>dementia unit following the implementation of a range of strategies has resulted in a rating of continuous improvement.</p> <p>Health and safety policies are implemented and monitored as evidenced in the monthly health and safety meetings. The village manager has overall responsibility for the health and safety programme with support from the health and safety team. A health and safety representative (RN) and village manager were interviewed about health and safety during the audit. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. The hazard registers for generic and specific hazards are reviewed a minimum of annually. The internal audit programme is linked to health and safety (e.g., food safety audits, emergency call bell audits, environmental audits, fire safety audits, waste management audits). Staff document hazards and near miss events via hard copy utilising the step-back cards. The village manager stated that he ensures staff are kept informed regarding any reported hazards. Incentive programmes are implemented to improve hazard reporting compliance with 20 hazards reported in March 2021 to September 2021. All staff complete health and safety training during their induction to the facility. This continues via staff comprehension competency questionnaires, in-service training, and staff meetings. Reception staff and/or maintenance staff are responsible for orientating external contractors through the Assure electronic system.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action(s) required. A review of fifteen incident/accident reports (witnessed and unwitnessed falls, episodes of challenging behaviours, one medication error) across all areas of the service identified that all are fully completed and include follow-up by a RN. The clinical manager is involved in the adverse event process and signs off on all adverse events. Neurological observations are completed over 72 hours following an unwitnessed fall or suspected injury to the head.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities including (but not limited to) a recent norovirus outbreak. Section 31 reports have been completed since the previous audit pertaining to a coroner's investigation, a resident assault and two residents who absconded.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (two staff RNs, six caregivers, one assistant to the manager, two activities coordinators, one housekeeper, one laundry) included a signed employment contract, job description, police check, induction paperwork relevant to the role the staff member is in, application form and reference checks. All files reviewed included a probationary performance appraisal followed by annual</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>appraisals.</p> <p>A register of health professional practising certificates is maintained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Educational courses offered include in-services, competency questionnaires, online learning and external professional development.</p> <p>Seventy-three caregivers are employed. Twenty-five have achieved their level three (or equivalent) Careerforce qualification and eleven have achieved their level four qualification. Seventeen caregivers work in the dementia unit. Nine of the seventeen caregivers and two activities staff have completed their Careerforce dementia qualification or equivalent. Eight caregivers are progressing through their dementia unit standards and have been employed for less than eighteen months.</p> <p>Registered nurses are supported to maintain their professional competency. RNs attend regular (two-monthly) journal club meetings, and webinars. There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including (but not limited to) infection control, medication and insulin competencies. At the time of the audit there were 15 RNs employed. Nine RNs (including the clinical manager) have completed interRAI training.</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, assistant to the manager and clinical manager/RN work Monday – Friday.</p> <p>The hospital wing (occupancy 36 hospital level residents) is staffed with a unit coordinator/RN Sunday - Thursday. Two staff RNs cover the AM and the PM shifts, and one RN covers the night shift. The AM shift is staffed with four long shift and four short shift caregivers, the PM shift is staffed with three long shift and three short shift caregivers and the night shift is staffed with two long shift caregivers. One fluid assistant covers the AM shift (short shift) seven days a week. A PM short shift lounge carer is rostered seven days a week.</p> <p>The dementia unit (occupancy 23 residents). A designated unit coordinator/RN works the AM shift (Tuesday - Saturday). A second RN is rostered on the days the unit coordinator is off. The AM shift and PM shifts are staffed with three caregivers (two long and one short shift). A lounge assistant is rostered a short shift on the PM shifts. The night shift is staffed with two caregivers.</p> <p>The rest home wing (24 rest home level and 1 hospital level resident) is staffed with one RN on the AM shift, seven days a week. Three caregivers (one long and two short) cover the AM shift, two long and two short shift caregivers cover the PM shift, and two caregivers cover the night shift. Oversight is provided by the hospital</p>

		<p>level RN on the PM and night shifts.</p> <p>Service apartments (11 rest home level residents) is staffed with one-unit coordinator/RN Sunday - Thursday. A senior caregiver is rostered on the two days that the unit coordinator is not available. The AM shift is staffed with two long and one short shift caregivers. The PM shift is staffed with three short shift caregivers with handover at 2200 to a designated night shift caregiver. Rest home level residents in the serviced apartments are clearly identified on the resident register and are communicated to the designated caregiver during handover.</p> <p>At the time of the audit there were five housekeeping vacancies (including two cover pool), two RN cover pool vacancies and 12 caregiver vacancies (including three cover pool and two recently appointed). Unfilled caregiver vacancies were in the serviced apartments (two), rest home (four) and hospital (one). A 'cover pool' of 60 RN hours are rostered every two weeks and 94 caregiver hours. These are additional staff that are added to the roster to help cover staff absences/vacancies.</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 resident and family interviews. Residents and family members interviewed reported that 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 files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</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. All potential residents are assessed by the needs assessment service coordination service (NASC) to determine level of care to be provided. The village manager and clinical manager screen all potential residents with the service. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack outlines the services and levels of care provided including specific information for families of relatives admitted to the dementia unit. Relatives interviewed stated they were well informed upon admission.</p> <p>The admission agreements reviewed for aligned with the service's contracts.</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 transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and the DHB 'yellow envelope' process is used. The RNs report that they include copies of all the required information in the envelope. Resident files reviewed included admissions to and from public hospital and all procedures, including documentation had been completed appropriately.</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 comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy.</p> <p>Registered nurses, and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Registered nurses have also attained syringe driver competency through the local hospice. There were two self-medicating rest home residents on the day of audit. Self-medicating competency, three monthly reviews, monitoring and safe storage were in place. The medication rooms were clean and well organised, all medications were in date and stored appropriately. The medication room and fridge temperatures are recorded, and these are within acceptable ranges. There are no standing orders in use.</p> <p>Twenty electronic medication charts were reviewed (six rest home, eight hospital and six dementia). Photo identification and allergy status was on all charts. All medication charts had been reviewed by the GP at least three-monthly. All resident medication administration signing sheets corresponded with the medication chart. All policy and legislative requirements had been met.</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>The meals at Ryman Ernest Rutherford are all prepared and cooked on site. The kitchen was observed to be clean and well organised. A current approved food control plan was in evidence which expires 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 lead chef (interviewed) was 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. Meals are plated by the chefs and delivered via hot boxes to the hospital unit. Meals are delivered by hot boxes and transferred to pre heated bain-maires and serviced by kitchen staff in the special care, rest home and serviced apartments. . Residents have access to</p>

		<p>nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily in the electronic app. 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 electronically. 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.</p> <p>The residents interviewed were very satisfied with 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 reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reason for declining entry to the service would be if there were no beds available or if the service could not meet the assessed needs for the potential resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the myRyman system within the required timeframes for all residents entering the service including short-stay residents. InterRAI assessments had been completed for all long-term residents whose files were reviewed. A suite of additional assessments is available in the myRyman system to be used according to need. The outcomes of all assessments, needs and supports required, were reflected in the myRyman care plans. Behaviour assessments had been completed for the files of the three dementia care residents with the outcomes included in the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	FA	<p>MyRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. 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</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>residents that included interventions and strategies for de-escalation including activities. 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, podiatrist, dietitian, district nurses and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP/NP consultation. Registered nurses interviewed stated that they notify family members about any changes in their relative's health status, which was confirmed during interviews with family members. Conversations and relative notifications via email are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. A sample of wounds were reviewed from each service level. There has been input from the district nurse (wound specialist) for chronic wounds. Photos of wounds demonstrated progress or deterioration. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically. There were no residents with a pressure injury on the day of the audit (link 1.1.8.1). All staff interviewed were knowledgeable around pressure injury prevention.</p> <p>Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan</p>	<p>CI</p>	<p>A team of activity and lifestyle coordinators (including two qualified diversional therapists – DT), activity assistants, and lounge caregivers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. Activities and lifestyle coordinators from each of the four units were interviewed. The coordinators working in the special care unit has completed the four dementia</p>

<p>for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>standards required. The activity and lifestyle coordinators work Monday to Friday in the rest home and serviced apartment units, and seven days a week in the hospital and special care unit.</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.</p> <p>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 two vans available for outings and a driver on staff available as required</p> <p>The hospital wing utilises a contracted, wheelchair accessible vehicle for their outings.</p> <p>Activities in the dementia care units include triple A exercises, singing, happy hours, hand therapy, word and memory games. There are also low-sensory activities if required including manicures and hand-massage. Community group, entertainer and pet therapy visits occur in all units. Happy hour occurs weekly.</p> <p>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.</p> <p>There are interdenominational church services held weekly in addition to individual spiritual support visits in the residents' rooms as required. Special events like birthdays, Matariki, St Patricks day, 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 and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>The resident files reviewed showed long-term care plans had six monthly reviews completed and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, NP, RNs, activities coordinators, physiotherapist and resident/family. Progress towards meeting goals were documented. Progress notes were completed and reflected response to</p>

comprehensive and timely manner.		interventions and treatments. Changes to care were documented. Documentation of GP/NP visits evidenced that reviews were occurring at least three-monthly. Short-term care interventions were in place for short term issues on the myRyman system.
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 group of 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 reassessed for a higher level of care. Discussion with the RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.
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 Consumers are provided with an appropriate, accessible physical environment and facilities	FA	The two-storey building accommodates the care centre and serviced apartments. The rest home and hospital units and serviced apartments are situated on the ground floor with the special care unit (dementia) and serviced apartments on the first floor. There is lift access between the floors. The facility has a current building warrant of fitness expiring in January 2022. The maintenance team includes two maintenance (one full time, one part time), and three gardeners. There is a planned maintenance schedule which has been maintained. A maintenance book is situated at the main reception area which is regularly checked each day. Electrical equipment has been tagged, tested and calibrated annually. Essential contractors are available 24/7. Hot

<p>that are fit for their purpose.</p>		<p>water temperatures are checked and records evidence these are maintained within expected ranges. The facility has wide corridors, and easy access to the outdoor areas.</p> <p>The special care unit is secure on the first floor, with an external courtyard with wall plantings and raised beds.</p> <p>Staff interviewed report they have adequate equipment to provide resident cares. Equipment available includes sensor mats, pressure relieving equipment, and a variety of hoists and manual handling equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All bedrooms are single with full ensembles. There are adequate numbers of communal toilets (located near the communal areas). Communal toilets have privacy slide signs. Residents 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>All residents' rooms are spacious enough to allow care to be provided safely and for the safe use and manoeuvring of hoists in dual-purpose rooms. 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</p>	<p>FA</p>	<p>Each area has an open plan lounge/dining area. There are other lounge areas, seating alcoves including a library available for quiet private time or visitors. There are communal areas including large lounges, small lounges and several seating alcoves throughout the facility. There is a large dining area in the large open plan living area in the special care unit. The special care unit has a separate small quiet lounge which is regularly used by residents as observed during the audit. The communal areas including the grounds and internal</p>

<p>with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>courtyards, are easily accessible and well maintained.</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. Laundry and cleaning audits are completed as per the internal audit programme. There is a team of dedicated laundry and housekeeping staff. All laundry is done on site. The laundry is divided into a “dirty” and “clean” areas. There is a laundry and cleaning manual and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system.</p> <p>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. The housekeeper and laundry assistant interviewed were knowledgeable around infection control practices and chemical safety.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster policies and procedures to guide staff in managing emergencies and disasters. The new staff induction programme covers emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. The retirement village has access to a diesel generator in the event of a power failure. There are civil defence supplies centrally located. Supplies of stored drinkable water is stored to ensure that there is a minimum of three litres available for each resident over three days. There is also a minimum of three days of food storage available. There are alternative cooking facilities available with gas barbeques and gas cooking in the kitchen.</p> <p>The facility has an approved fire evacuation plan and fire drills take place six-monthly. The call bell system is evident in residents’ rooms, lounge areas and toilets/bathrooms. Residents are provided with alarm pendants in addition to access to a call bell next to their bed and in their ensuites. There are closed circuit cameras strategically placed throughout the facility. Staff conduct security checks at night in addition to an external contracted security company.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. There is underfloor heating throughout the facility. The service has consulted an electrician regarding individually thermostat-controlled switches in all resident rooms. All rooms have external windows with plenty of natural sunlight. Residents and relatives confirmed satisfaction with the temperature of the facility.</p>

<p>with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		
<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>	<p>FA</p>	<p>The Ryman organisational infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control coordinator is the clinical manager. A job description 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.</p> <p>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. Residents and staff are offered the influenza vaccine. There has been one outbreak (norovirus) in 2021 which was appropriately managed and included liaison with the local DHB and public health unit.</p> <p>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.</p> <p>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 and complete a wellness check on arrival to the facility. All visitors are required to wear a mask (in line with the current level 2 lockdown guidelines) and declare whether they have been vaccinated with the Pfizer Covid 19 vaccine.</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</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Ryman Ernest Rutherford. The infection control committee meet two-monthly, with information then being discussed as part of staff meetings and also as part of the registered nurse meetings. The infection prevention and control leader has completed training in infection control. Infection prevention and control coordinator has access to an infection prevention and control nurse specialist from the DHB, microbiologist, Bug Control, public health, GPs, local laboratory and expertise from within the organisation.</p>

organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate. Policies and procedures include Covid19 guidelines and protocols.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection prevention and control leader is responsible for coordinating/providing education and training to all staff. The infection control coordinator has attended external training sessions around Covid 19 and a session on antimicrobials. 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. Extra training has been added to the education calendar around Covid 19 including donning and doffing personal protective equipment, isolation protocols and standard precautions. Infection control is an agenda item on the full facility and clinical meeting agenda.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	CI	<p>The surveillance programme is organised and promoted via TeamRyman. Effective monitoring is the responsibility of the infection prevention and control coordinator.</p> <p>An individual infection report form is completed for each infection. Data is logged into an electronic system, which gives a monthly infection summary. This summary is then discussed at the two monthly meetings and all facility meetings. Any trends are analysed, and solutions discussed and implemented. All meetings held include discussion on infection prevention control. The infection control programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and</p>

control programme.		<p>kitchen hygiene. Infection rates are benchmarked across the organisation.</p> <p>There has been a focus on reducing skin and wound infections across the facility. A wound champion has been appointed, who reviews all wounds in the facility. The wound champion liaises closely with the district nurses (local wound specialists) and the Ryman wound care specialist. Regular in-services have been provided to nurses around wound management and skin integrity. This has resulted in a reduction of skin and wound infections to remain below the target range and group range of 0.35 to 1.77 per 1000 bed nights.</p> <p>The recent outbreak of Norovirus in 2021 was well documented and managed. The public health team were informed promptly. Daily meetings and logs were maintained. A debrief meeting was held post outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit, two residents were using restraints and no residents were using enablers.</p> <p>Restraint policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. Staff training has been provided around maintaining a restraint-free environment as well as strategies to manage challenging behaviours and minimise falls.</p>
<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	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (RN) 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.</p>
<p>Standard 2.2.2: Assessment</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, resident and their family/whānau undertakes assessments. Restraint</p>

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital-level residents' files were reviewed. Both residents were using chair briefs as a restraint. Completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is the hospital level unit coordinator and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialed before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to each resident's care plan. Internal audits, conducted six-monthly, measure staff compliance with following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two residents' files where restraint was in use.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint approval group meetings are held six-monthly and include the clinical manager, restraint coordinator, one staff RN and one GP. Agenda items include discussing progress on how the facility is working towards becoming restraint-free. Alternative measures include engaging activity programmes, scheduled toileting, meeting the residents' individual needs, one on one interactions with residents, falls prevention strategies and pain management.</p> <p>The restraint evaluations occur six-monthly (at a minimum) as part of the ongoing reassessment for residents using restraint. Families are included as part of this review and re-sign a restraint consent form every six months.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality</p>	<p>FA</p>	<p>Restraint usage throughout the Ryman organisation is monitored regularly. The review of restraint use is discussed at an organisational level and at relevant facility meetings. The Ryman organisation and facility are very proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes staff completing a competency in relation to restraint minimisation.</p>

review of their use of restraint.		
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Examples of good practice are evident with maintaining a pressure injury free environment highlighted as a continuous improvement.</p>	<p>As per clinical indicator data analyses, Ernest Rutherford has maintained a target of no pressure injuries from July 2020 to present (12 October 2021). The clinical manager interviewed confirmed a rigorous action plan was implemented to attain this high standard of care. Residents are correctly assessed on admission and risk factors are clearly identified. Residents with high risk factors have interventions in place from the time of admission. Referrals to allied health professionals (e.g., dietician, speech language pathologist, physiotherapist, podiatrist) are activated where risks are identified. High protein diets are available and moulded foods are placed in food moulds to increase appeal. The clinical manager reported that the single most significant action implemented to achieve this high standard is based on staff education around pressure injury management, not only RN education but education for all care staff (e.g., nutrition and hydration training, pressure injury management training, training to address monitoring residents' positions and observations of discomfort). Residents are monitored regularly for</p>

			positioning and observing any signs of discomfort.
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Robust systems are in place for the collection, analysis and evaluation of quality data. A range of data is collected across the service using V-Care, an electronic data management system. Data is collated and analysed with comprehensive evaluation reports completed. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other similar service types within Ryman facilities. Communication of results occurs across the range of meetings. 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 collected around (but not limited to): falls, skin tears, pressure injuries and infections. Results regarding falls data reflects low rates, particularly in the dementia unit, and has resulted in a rating of continuous improvement.</p>	<p>Falls data in the dementia unit reflects ten of eleven months of data below the Ryman benchmark (10 falls per 1000 bed nights). Falls have dropped to rates as low as 2.59, and only exceeded target during one month with two acutely unwell residents. Strategies implemented to achieve this positive outcome address the resident population in the dementia unit as a whole as well as each individual high-risk resident. For example, interventions for one resident included raising their toilet seat and placing arm rests next to the toilet to assist with mobility. Falls dropped from 1.35/1000 bed nights (Nov 2020) to none in March 2021 and July 2021. Another resident has benefitted from a lipped mattress and earlier intentional rounding during the PM shift. Falls for this resident dropped from 3/1000 bed nights (Feb 2021) to nil (current). Another successful strategy implemented for all the dementia level residents includes keeping residents occupied during daytime hours. During the audit, observations were made that reflected an activities coordinator who was very successful in engaging the residents (link CI 1.3.7.1). Lounge assistants, intentional rounding, and regular toileting are other strategies that have proved successful.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>Following feedback received from the 2020 satisfaction survey, it was identified improvements could be made around improving residents delight through meal service, menus, options and service. The aim was to continue to offer tasty nutritious and well-presented food that residents enjoy which will create a huge impact on resident health outcomes and quality of life.</p>	<p>Project delicious is embedded into the service. Food services are discussed at the weekly management meetings, and the full facility staff meetings. Prior to lockdown, there was a 'chefs table' where the chef dined with the residents and discusses the menu and meal options. The chef attends resident meetings as required. Residents are offered a tour of the kitchen so they can see how their meals are prepared and delivered to the dining rooms. The dining rooms are set up like restaurants, with background music. Residents are offered choices to promote freedom of choice, independence, and value as a person, providing residents with the choice in another part of their lives. Staff have received education</p>

			<p>around nutrition and hydration, and kitchen staff receive education around implementation of the new menu.</p> <p>The new café offers a change of environment and is enjoyed by residents and relatives from all service levels.</p> <p>These changes have improved satisfaction from 3.70 out of five in 2020 to 3.73 in 2021. Staff and management report the atmosphere in the dining rooms is lighter and there is less wastage on plates, evidencing residents are enjoying their meals. Residents and relatives interviewed during the audit were complimentary of the food services.</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 a plan is developed for the residents around activities.</p> <p>The activities team continue to adapt the programme amidst the restrictions of the pandemic with the aim to promote self-worth, personal achievement and pride for residents, to develop skills that have either been 'lost' or not yet explored, and for residents to engage with purposeful but meaningful activities. The activities programme is based around themes rather than activities, this includes arts and crafts, speakers, entertainers that deliver an experience rather than isolated activities. This was witnessed during the audit in the special care unit where the activities coordinator had a large group of residents engaged with saying the first few lines of a song, and the residents were joining in singing the song, one the first resident recognised the song, others joined in singing.</p>	<p>The activities calendar was revisited, alternative activities were offered to residents during the lockdown period, which included the use of zoom for video calls and exercises.</p> <p>There are structured activities offered daily, which includes evening activities in the hospital and special care unit. There are happy hours and entertainment held regularly which continued to be held through zoom during lockdown periods, with 'goodie' packs distributed for residents to enjoy. The activities team meeting minutes evidenced discussion around activities held and increasing attendance rates. There is a wide range of community involvement as lockdown restrictions allow, there are regular visits from school students, bus rides, church services and guest speakers. A wide range of village activities include children's day, Anzac Day, family barbeques, and the Ryman Olympics to name a few. The 2021 satisfaction survey evidenced an increase in satisfaction from 4.00 out of 5 to 4.16 out of 5. Monthly attendance records continue to rise and there is regular feedback from relatives and residents. The relatives and residents interviewed described arts and crafts, staff being interactive with residents, exercises, and the wide range of activities available throughout the service levels.</p>

<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Benchmarking across the organisation indicated Ernest Rutherford has maintained low rates of urinary tract infections across all service levels since June 2020. There has been a focus around increasing preventative measures including the introduction of fluid rounds, analysing and trending data across all service levels and reducing antibiotic usage.</p>	<p>This involved educating the RNs around not relying on the use of urine 'dip sticks' to diagnose infections, instead looking at symptoms. Residents must have three or more symptoms of infection to obtain a sample for microbiology testing so correct treatment can be prescribed. Education and comprehensive surveys were completed around nutrition, hydration and urinary infections, and the increased risk with warmer weather. Sessions were held around the use of continence products, and hygiene. Benchmarking data continues to evidence the very low rates of urinary tract infections for care centre residents at 0.00 – 1.44 per 1000 bed nights, this is directly proportional to the low antibiotic usage. There were no urinary tract infections in the months of September 2020, January, February and May 2021.</p>
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End of the report.