

Essie Summers Retirement Village Limited - Essie Summers Retirement Village

Introduction

This report records the results of a Surveillance 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:	Essie Summers Retirement Village Limited
Premises audited:	Essie Summers 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: 5 October 2021 End date: 6 October 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	91



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

'Essie Summers Retirement Village referred to in the report as Essie Summers provides rest home, hospital and dementia level care for up to 95 residents in the care centre. There are also 30 serviced apartments certified for rest home level of care. On the day of audit there were 91 residents in total.

This unannounced surveillance audit was conducted against a sub-set of 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 at Essie Summers has a clinical background and has managed the service for 15 years. She is supported by a clinical manager who has been in the role for one week and an experienced assistant resident services manager.

The service has addressed the one previous audit finding around documentation of administration of medication.

Areas of continuous improvement were identified around quality initiatives, restraint free environment and infection surveillance.

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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Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

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 comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes. Residents receive appropriate services from suitably qualified staff.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training are 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

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.



Standards applicable to this service fully attained.

Registered nurses are responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs when health changes against outcomes and goals. Care plans reviewed are based on the interRAI outcomes and other assessments. Families interviewed confirmed they are involved in the care planning and review process. There is a minimum of a three-monthly resident review by the general practitioner. The registered nurses complete care plans and evaluations.

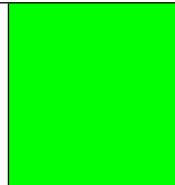
There is a group activity programme and individual activity plans have also been developed in consultation with family. The activity programme includes meaningful activities that meet the recreational needs and preferences of the dementia, rest home and hospital level residents.

Medicines are stored, managed, and administered appropriately. There are regular visits and support provided by the community mental health team and other allied health professionals.

All meals are prepared on site. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place that also includes calibration and testing of equipment and monitoring of hot water temperatures. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and well maintained. The special care unit is secure.

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.		All standards applicable to this service fully attained with some standards exceeded.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with enablers and four residents with restraint at the time of the audit. Staff receive training around restraint minimisation and enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is a monthly surveillance programme, where infections are collated, analysed, and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings and management quality meetings. There has been one outbreak since the last audit, and this was managed appropriately. The service has implemented Covid-19 prevention strategies.

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	1	15	0	0	0	0	0
Criteria	3	38	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at the Essie Summers facility. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and village manager are involved in clinical complaints. The facility has an up-to-date complaint register for each unit. Concerns and complaints are discussed at relevant meetings. There have been four complaints made in 2020 and three complaints received in 2021 year to date. Complaints have been acknowledged and addressed within the required timeframes.</p> <p>Residents and relatives interviewed were knowledgeable about the complaints process and stated the manager and clinical manager were always available to answer concerns.</p> <p>Eighteen staff (seven care staff, four-unit coordinators, 2 registered nurses (RN's), one DT , three activities coordinators and a chef) interviewed confirmed they had received training and understood the complaints process.</p> <p>There have been no external complaints since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>There is an incident reporting policy that guides staff to their responsibility to notify family of any resident accident/incident that occurs. Fourteen incident forms reviewed evidenced the family had been informed of the accident/incident. Four relatives interviewed (two hospital and two dementia), stated that they are informed when their family members health status changes. Six monthly relative meetings occur in each of the units (rest home,</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>hospital, and dementia care). Four residents (two hospital and two rest home) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>Specific introduction information is available on the dementia unit for family, friends, and visitors to the 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. An interpreter policy and contact details of interpreters is available. The information pack is available in large print, and this can be read to residents.</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>Essie Summers is a Ryman healthcare village located in Christchurch. The service provides care for up to 95 residents at hospital, rest home and dementia level care and 30 serviced apartments certified for rest home level of care. On the day of audit there were 91 residents in total: 29 of 30 rest home residents including one resident on a respite care contract on level one, 40 of 41 hospital level residents including two residents on end-of-life contracts on level two, 21 of 24 dementia care residents on level three. There was one rest home level of care resident in the serviced apartments at the time of the audit. There were no residents under the medical component of the certificate at the time of audit.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are translated at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific village objectives 2021 and progress towards objectives is updated as part of the TeamRyman schedule.</p> <p>The village manager at Essie Summers is a registered nurse with a current practising certificate and has been in the role for 15 years. She is supported by a clinical manager who has been in the role for one week (she worked previously at Ryman Anthony Wilding as a Unit Coordinator) and an assistant resident services manager, who has been in the role for six years. The village manager is also supported by a regional operations manager (who was present at the time of the audit).</p> <p>The village manager has maintained over eight hours annually of professional development activities related to managing an aged care facility including attending annual Ryman training days. The clinical manager has been in the role for one week and a comprehensive orientation is being implemented. In her previous role as a unit coordinator, the clinical manager received ongoing training including clinical and management training including falls prevention management and complaints management.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>Essie Summers service 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</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>the management team (village manager and clinical manager) 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. There has been a decrease in the residents' overall satisfaction average score from the previous year from 4.60 to 4.16. Corrective actions have been established around food satisfaction, housekeeping and documentation and communication. The service scored well around a new question related to Covid safety at 4.59 and communication at 4.36.</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 health and safety officer (caregiver) was interviewed. She has completed level one external health and safety training. Health and safety meetings are conducted bi-monthly. 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. A new system "Donesafe" has been recently introduced for use by all staff. Donesafe is used for the entry of all staff incidents, resident incidents, and hazards. The system is accessed via an online staff information app "ChattR". The organisation promotes staff wellness and has implemented a number of initiatives to show appreciation of staff during Covid lockdown. Hydration stations promote adequate fluid intake. The noticeboard and a staff information app keep staff informed on policy changes, Covid alert levels changes, health and safety, infection control and meetings. Care staff stated they felt valued and supported by management and the organisation.</p> <p>Falls prevention strategies are in place that include ongoing falls assessment, routine checks of all residents specific to each resident's needs (intentional rounding) and encouraging resident participation in the triple A exercise programme.</p> <p>The service has achieved a continuous improvement in relation to falls reduction and pressure injury reduction.</p>
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<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>	<p>FA</p>	<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 14 incident/accident forms for August and September 2021 from across all areas of the service, identified they all are fully completed, including follow-up by a registered nurse (RN) and relative notification. Post falls assessments included neurological observations for four unwitnessed falls with potential head injuries. The clinical manager is involved in the adverse event process, with links to the applicable meetings (TeamRyman, full facility, clinical, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations that would be reported to statutory authorities. There have been ten section 31 notifications made since the last audit including four for missing rest home residents, one absconding resident, one unstageable and three stage three pressure injuries, and a respiratory syncytial virus (RSV) outbreak.</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. Eight staff files reviewed (one clinical manager, two-unit coordinators, one registered nurse [RN], three caregivers and one activity coordinator) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN and health professional practising certificates is maintained and current. An orientation/induction programme provides new staff with relevant information for safe work practice. 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.</p> <p>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. Registered nurses are supported to maintain their professional competency. There is regular RN journal club. Forty-four staff including RNs, the management team, activities staff and senior carers hold a current first aid certificate. An additional 24 staff have completed a CPR workshop. There are implemented competencies for RNs, enrolled nurses [ENs] and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Caregivers are encouraged to gain qualifications with the New Zealand Qualification Authority (NZQA).</p> <p>There are 18 RNs working at Essie Summers and six RNs have completed interRAI training. There are sixteen caregivers work in the dementia unit. Thirteen caregivers have completed their dementia standards and a further three who have started employment in the last six months have commenced Careerforce 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>Ryman organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. There is a pool of casual staff to cover unplanned absences. Unit coordinators are responsible to ensure cover for unexpected changes within their units. The village manager works Monday to Friday and the clinical manager works Sunday to Thursday. Both are on call 24/7 for any operational and clinical issues respectively. They are supported by four-unit coordinators/RNs in the rest home, hospital, dementia, and the serviced apartments.</p> <p>Staffing at Essie Summers is as follows:</p> <p>In the rest home unit there are 29 of 30 residents, there is a unit coordinator Tuesday to Saturday with an RN on Sunday and Monday on the morning shift. There are three caregivers (two full and one short-shifts) on the morning and afternoon shifts and two caregivers on night shift.</p> <p>In the hospital unit there are 40 of 41 residents, there is a unit coordinator who is supported by two RNs on duty on the morning and afternoon shifts, and one RN on night shift. There are eight caregivers (four full and four short-shifts) and a fluids assistant on morning shift, six caregivers (two full and four short-shifts) and a lounge carer on afternoons, and two caregivers on night shift.</p> <p>In the dementia care units, there are 21 of 24 residents. There is a unit coordinator/RN Tuesday to Saturday with an RN on Sunday and Monday on the morning shift. There are three caregivers (two full and one short-shift) on the morning shift. On the afternoon shift there are two caregivers (one full and one short-shift) and a lounge carer from 4 pm to 9 pm. At night there are two caregivers working full shifts.</p> <p>The hospital RN covers the rest home unit on the afternoon and night shifts and the dementia unit on the night shift.</p> <p>In the 30 serviced apartments there is one rest home level resident. There is a unit coordinator/RN on the morning shift from Sunday to Thursday and a senior caregiver on Friday and Saturday. There are two caregivers on the morning and afternoon shifts. Caregivers from the rest home cover the serviced apartments on the night shift.</p> <p>Activities are provided seven days a week for all residents in the care centre. A registered physiotherapist is available two mornings a week totalling six hours. A physiotherapy assistant works Monday to Friday from 9 am to 12 noon. There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Seven caregivers interviewed (two hospital, two rest home, two dementia care and one from the Ryman cover pool) stated the RNs are supportive and approachable. Interviews with residents and relatives indicated that overall there are sufficient staff to meet resident needs.</p>
<p>Standard 1.3.12: Medicine</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of four weekly blister</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>packs is completed by one RN and one senior caregiver and any errors fed back to the pharmacy. Registered nurses, and caregivers who administer medications have been assessed for competency.</p> <p>The service uses an electronic medication system. Care staff interviewed could describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges and room temperatures were monitored daily. All eye drops and creams in medication trolleys were dated on opening. There are no standing orders.</p> <p>Internal audits for medication management have been completed and no corrective actions were required. Medication errors are documented as incidents and reported and followed up as part of the quality programme. Medication management education has occurred within the last 12 months.</p> <p>There were two self-medicating residents in the rest home on the day of the audit and competency documentation completed as required. The medications are kept in a locked drawer in the residents' rooms. The RNs assess competency three-monthly which is signed off by the GP. The competency documentation is kept on myRyman.</p> <p>Twelve charts were reviewed on the electronic medication system. All medication charts had photographs and allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system.</p> <p>Medication entries in the medication register complies with relevant guidelines and legislation. The improvement required identified at the previous audit has now 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>	<p>FA</p>	<p>All food and baking is prepared and cooked on site. There are two qualified chefs supported by kitchen assistants. Meals are transported in hotboxes to the servery areas in the units. The food is served and plated by caregivers with support from the cook assistant.</p> <p>The chef maintains regular contact with the residents when serving meals and to observe the dining experience. Meals for the serviced apartments are delivered in hot boxes. All staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with the company chef and the dietitian at organisational level.</p> <p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft, diabetic desserts, vegetarian, and gluten free are provided. A food control plan is in place and due to be reviewed in May 2022.</p> <p>Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily on an electronic food service management system. Chilled goods temperature is checked on delivery. Twice daily food temperatures</p>

		<p>are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained.</p> <p>There are snacks available for residents 24/7 including fruit platters. The lunch meal was observed in the special care unit and special utensils were available for the residents that required it.</p> <p>Feedback on the service is received from daily resident contact, resident meetings, surveys, and audits.</p> <p>The residents interviewed as part of the audit were complimentary of the meals and overall dining experience.</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>Four residents interviewed reported their needs were being met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. The myRyman 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 provides caregivers the opportunity to sign the task has been completed. 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, completes the short-term care plan. Evaluations of the care plan stated if individual goals are met or unmet.</p> <p>Wound assessments, treatment and evaluations were in place for thirteen residents with wounds in the last thirty days, and all wounds had been resolved at the time of the audit. All wound assessments and management plans and evaluations are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. The registered nurse interviewed could describe access to the wound specialist nurses, continence nurse and the dietitian if required. There is one RN that holds the portfolio of wound champion and one pressure injury prevention champion. Both had completed formal training for their respective portfolios to assist with management of wounds and pressure injuries.</p> <p>There were thirteen wounds (two in the dementia, three in the rest home and eight in the hospital) managed across the service including two chronic wounds. There were no residents with pressure injuries. There was evidence of wound nurse specialist input and review with both chronic wounds.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>The four family members interviewed stated their relative's needs were being appropriately met.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>There is a team of five activities coordinators (two qualified diversional therapists, two enrolled to complete the qualification and a part-time activity coordinator) deliver the Engage programme across the rest home, hospital, special care unit and serviced apartments. All have current first aid certificates. The activities programme for the</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>hospital, special care unit and rest home is set over seven days a week. There are lounge carers in the hospital and special care unit in the afternoon that can assist with activities and de-escalation of behaviour when required.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group. There was one resident in the serviced apartments at the time of the audit. The resident interviewed confirmed that they are involved in the activities programme for either the rest home or serviced apartments. There are adequate resources available for caregivers to assist with activities.</p> <p>There is a monthly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of 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 serviced apartments 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. There are regular combined activities and celebrations held in the large lounges and atrium for residents from all the units. Residents in the special care unit (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision.</p> <p>Activities in the special care units include triple A exercises, garden walks in the two courtyards and around the village, singing, happy hours, hand therapy, word games, knitting group and dancing. Cultural groups and pet therapy visits (to all units) are included in the programme. Two files were reviewed of residents in the special care unit. Both included integrated activities of daily living that supported activities/interests across 24/7. Behaviour management/de-escalation plans were documented.</p> <p>There are interdenominational church services held in the chapel with room visits as required. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day and Christmas and theme days are celebrated. Junior school children and kapa haka groups visit.</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, likes and dislikes. 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 and interRAI assessment. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered. Resident/relative survey results of February 2021 showed a satisfaction rate for care, communication, and activities between 4.15 and 4.3 out of 5.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	<p>FA</p>	<p>Long-term care plans had been evaluated by registered nurses at least six monthly and when there are changes in resident condition. One resident care plan has been updated to indicate instructions post discharge from hospital. The respite care resident file and resident on palliative (end-of-life) care documented reviews and updates to care</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>as needed.</p> <p>The multidisciplinary review involves the RN, GP, physiotherapist, activities coordinator and caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one to three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan. Evaluations for residents describe the residents' progress against the residents' identified goals and any changes are updated on the long-term care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 July 2022. There is an approved fire evacuation scheme. The building includes three levels with the rest home on level one, hospital on level two, and the secure special care unit on level three. All floors are accessible by lift and emergency stairs. The lifts are spacious to accommodate ambulance transfer equipment. The serviced apartments are attached to the care facility. Each unit including the serviced apartments have their own medication/treatment room and nurses' station.</p> <p>The facility corridors are wide and provide space for residents to mobilise using mobility aids. Residents are able to access the outdoor gardens and courtyards safely with mobility aids. Seating and shade is provided. The caregivers and registered nurses interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plan.</p> <p>The maintenance person works one day a week and is available for two days if required, and a full-time gardener addresses daily maintenance requests. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of weigh scales, hoists, oxygen concentrators and electric beds. Hot water temperatures in resident areas are monitored and stable. Contractors are available 24/7 for essential services.</p> <p>External areas and pathways are well maintained with an external area with raised gardens accessible from the lounge in the special care unit.</p> <p>There have been no physical changes to the environment since the last audit. Refurbishment including painting is part of the maintenance programme.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. One</p>

<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>respiratory outbreak was reported (June/July 2021) to Public Health since the last audit. The outbreak was contained and managed appropriately.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and staff have received both doses of the Pfizer Covid-19 vaccine. Residents and staff are offered the influenza vaccine. Covid-19 scanning/sign in is mandatory on entry to the facility and the use of face masks is required as part of level 2 restrictions.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>The service has been awarded a continuous improvement for the reduction of urinary tract infections and antibiotic stewardship and their response to Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>CI</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>During the audit, there were no residents using enablers and no residents with restraints. The service has maintained a restraint free environment since February 2015. The restraint coordinator (currently a hospital unit coordinator) provides staff training around restraint minimisation and de-escalation of challenging behaviours.</p> <p>The service has been awarded a continuous improvement for maintaining a restraint free environment.</p>

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
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	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. Quality improvement plans (QIP) are developed where results do not meet expectations. 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,	Falls and pressure injuries were identified in 2018 as areas that could be improved. An initial plan to reduce falls was developed which included identifying residents at risk of falling, providing falls prevention training and repositioning training to reduce roll out of bed, use of perimeter guards, intentional rounding, annual ear health checks to promote balance, protein smoothies to build muscle strength, utilising wall sensors compared to floor sensors to minimise trip hazards and improved hydration and nutrition. In 2020 and 2021 the service looked at ways of ensuring the low falls rate the service has achieved was maintained. Further initiatives implemented included a resident review guide and multi-disciplinary meetings for repeat fallers. Training on positioning was expanded to include chairs and further review of bed positioning. Repeat fallers had intensive review by the GP with an emphasis on review of medications which may contribute to risk factors. Care assistants interviewed were knowledgeable in regard to preventing falls. Fall reduction plans have been reviewed monthly and discussed at staff

		<p>timeframe, and the status of the actions. Falls and incidents are discussed at the handovers between shifts to ensure staff are up to date with current information.</p>	<p>and management meetings.</p> <p>The falls rate for hospital and rest home level residents has been maintained at well below the group average. The outcome achieved is that the total of rest home and hospital resident falls has decreased from a rate (per 1000 occupied bed days) of 7.5 falls per month April 2018 down to 4 falls per month in September 2021. Essie Summers falls rates across hospital and rest home have been consistently below the Ryman average throughout 2020 and 2021.</p> <p>An initial plan to reduce pressure injuries was developed in 2018. The initial plan included in-service training, increased procurement of pressure relieving equipment, improved nutritional assessment and increased protein intake, monitoring, and promoting weight gain use of the Molicare skin regime, correct positioning of at-risk residents, improving skin assessment and intentional rounding. The plan was further enhanced in 2020 and 2021 with the establishing of a pressure injury prevention champion role, a heal the heels campaign, dysphagia training, podiatrist review of footwear and at-risk residents and staff training on foot care.</p> <p>The pressure injury rate of all stages for facility acquired at Essie Summers has been maintained at well below the group average since 2018. There has been no facility acquired stage 3 or 4, unstageable or deep pressure injuries since July 2020. There has been one stage 1 and two stage 2 pressure injuries since April 2020. The outcome of the plan is that the number of pressure injuries in the hospital have been maintained at 0.18 per 1000 beds between 1 January 2020 to 1 October 2021.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving</p>	<p>CI</p>	<p>Ryman Essie Summers is proactive in developing and implementing quality initiatives. Quality improvement plans (QIP) are developed where results do not meet expectations. There is a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. An electronic</p>	<p>The following initiatives proved to have positive resident outcomes:</p> <p>a) Ryman Essie Summers implemented strategies for the reduction of urinary tract infections. Strategies included identified residents experiencing regular urinary tract infection and complete individual detailed strategies including toileting regime, review of continence products with assistance of a continence advisor, monitor and control of blood sugars with nutritional strategies and introduction of a fluid menu and hydration stations to improve and support increase in fluid intake.</p>

<p>infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>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. Ryman Essie Summers continued with their efforts to keep the urinary tract infections below 5.5/per 1000 beds since 2013.</p>	<p>All staff completed continence management education and related topics discussed at handover. Fluid assistant roles were added to the morning shift for the hospital and special care unit to support resident's hydration needs. Related data is available for all staff to view and recorded in the relevant meeting minutes. Documentation reviewed identified that strategies were regularly evaluated. The outcome achieved was that urinary tract infections recorded between 000-1.52 per 1000 bed days between January 2020 and August 2021. The monthly graph demonstrates a continued and sustained downward trend apart from two spikes which could be explained by an individual resident ill health.</p> <p>Ryman Essie summers increase residents, relatives, and staff awareness of antibiotic usage in relation to emergence of superbugs through staff training and resident/relative meetings. The medication advisory committee works with the GP (confirmed with interview) to ensure urinary tract infections are treated symptomatically. Antimicrobial use has decreased from 18.2% in 2019 to 12.2% in 2020. Three residents reviewed as an example where prophylactic antibiotics were successfully discontinued without any adverse effect on their health.</p> <p>b) Ryman Essie Summers implement 'safe haven' project to ensure the response to Covid-19 is structured and consistent. Increased communication with staff through ChattR with Covid-19 related information (GO KIT) from Ryman Christchurch Covid Emergency response team. The facility completed Covid-19 virtual drills monthly to ensure consistency in their response to Covid-19; this includes an increased use of PPE and isolation and handwashing/cleaning practices when any respiratory symptoms appear. The GPs implemented telehealth to ensure residents receive the appropriate care in a timely manner. The facility completed successful rollout of Covid-19 vaccinations for staff and residents. Data related to respiratory infections were recorded 0.00-0.82 lower than group average (with months with no respiratory infections recorded) of 1.71/1000 beds between January 2020 to May 2021 (a spike in December 2020 due to two residents with COPD and June/July 2021 due to upper respiratory tract virus outbreak).</p>
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<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>CI</p>	<p>A review of the clinical indicator data in October 2021 identified Ryman Essie Summers has maintained a restraint free environment since 2015. Meeting minutes reviewed evidenced discussions around strategies to maintain a restraint free environment. Care staff interviewed could explain current strategies that assist to keep the environment restraint free.</p>	<p>The service wanted to continue to support residents' independence and safety with proven strategies and initiatives that maintains the restraint free environment. Essie Summers has been restraint free since 2015 and actively focuses on supporting this status. This includes continuing proven strategies such as responding to specific resident needs including falls prevention, early intervention to identify changes in behaviour, regular review of medication, safe environment for wandering including a dementia friendly design with low stimulus areas, review of timing of other activities and individual schedules/routine.</p> <p>Ryman is committed to their responsibility of providing adequate staff levels and skill mixes to meet the needs of the residents. Rosters include physiotherapy assistants in each hospital unit to promote residents' independence through mobility support and exercise, lounge carers oversee residents in the lounge area in the dementia unit and hospital and assist with supervision, activities and de-escalation where required, and fluid assistants in the hospital unit ensures residents are adequately hydrated. Education sessions for staff were provided to include education on restraint, risks of restraint, restraint minimisation practices and management of challenging behaviours and individual intervention strategies. This resulted in a continuing understanding for existing and new staff of the importance of early intervention and encourages staff input into residents' cares. Essie Summers also increased supplies of wall sensors, floor sensors, bed sensors and perimeter guards. Implementation of a of Move and Groove programme in the special care unit reduced distressed behaviours and restlessness and assisted staff to identify trends in times or locations and incorporate this into the care plans. This has resulted in a calm environment and low usage of antipsychotic medications. Care staff interviewed were confident in the use of strategies to redirect behaviours that challenge.</p> <p>Residents and families are well informed regarding the Essie Summers goal of maintaining a restraint free facility and the benefits this provides for residents. This resulted in an increased understanding of the importance of early intervention, encouraged staff input into residents' cares and empower staff through accountability.</p> <p>The data evidenced the service maintained the restraint free environment since 2015 start of the initiative with no incidences of restraint or enablers reported. Quality data related to incidence of</p>
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End of the report.