

# Shona McFarlane Retirement Village Limited - Shona McFarlane Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Shona McFarlane Retirement Village Limited
<b>Premises audited:</b>	Shona McFarlane Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 December 2021      End date: 16 December 2021

**Proposed changes to current services (if any):** One room in rest home unit (Sunflower) is decommissioned to be included in the current refurbishment and extension of the care facility to include a new reception, rest home lounge, offices, and café. This will

decrease the total beds in Sunflower wing from 39 to 38 and the total number of certified dual-purpose beds in the care centre from 79 to 78.

**Total beds occupied across all premises included in the audit on the first day of the audit: 76**

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Shona McFarlane Retirement Village is operated by Ryman and provides rest home and hospital level care for up to 98 residents, including 20 serviced apartments certified to provide rest home level care. At the time of the audit there were 76 residents in total including four rest home residents in the serviced apartments.

One rest home room in the care centre was decommissioned to include the current building of an extension to the care centre. The total bed numbers in the care centre decreased from 79 to 78.

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

The village manager (non-clinical) has been in the role for six months with previous hospitality experience and an experienced business manager. They are supported by a clinical manager has been in the role for three months and has experience in aged care in clinical management roles. They are supported by an assistant to the manager, three-unit coordinators, RNs, and caregivers. The management team is supported by the Ryman management team including regional operations manager.

There are systems, processes, policies, and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisation's quality and risk management programme. An induction and in-

service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Covid 19 prevention strategies are incorporated into the daily operations of the facility.

This audit identified no areas of improvement.

The service is commended for achieving continuous improvement ratings around recognition of good practice, falls prevention, maintaining a restraint free environment.

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

## Organisational management

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



Standards applicable to this service fully attained.

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

## Continuum of service delivery

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.

There is a comprehensive information package for residents/whanau on admission to the service. Registered nurses are responsible for each stage of service provision including assessments, risk assessments, care plans and evaluations, which are updated at least six-monthly. Care plans demonstrate service integration and the residents/family interviewed confirmed they were involved in both the initial care planning process and ongoing review. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

Medication policies and processes reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines and have completed annual competencies and education. Medication charts are reviewed three-monthly by the GP.

The activity team provides an activities programme which is varied and interesting for each resident group. The engage programme meets the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links and there are regular entertainers, outings, and celebrations.

The menu is designed by a dietitian at an organisational level. All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

## Safe and appropriate environment

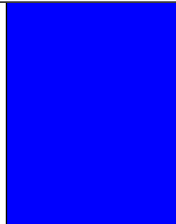
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. All bedrooms have ensembles, additionally there are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility with hallways and communal areas being spacious and accessible. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available.

There are policies, systems, and supplies in place for essential, emergency, pandemic, and security services, including adequate civil defence/emergency water stocks. First aid trained staff members are on duty at all times.

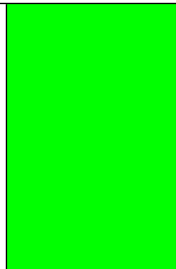
Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site. Both departments have appropriate policies and product safety charts in place and quality standards are monitored through the internal auditing system. Chemicals are stored safely throughout the facility.

## 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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Restraint minimisation is practiced and overseen by the registered nurse. There were no residents using enablers or restraints. Staff receive training around restraint minimisation and management of challenging behaviour.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Covid 19 prevention strategies aligns with the national Covid19 preparedness framework. The infection control officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer has



attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	2	43	0	0	0	0	0
<b>Criteria</b>	3	90	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Four managers (village manager, assistant to the manager, clinical manager, and regional operations manager) and 18 staff interviewed; including three registered nurses (two-unit coordinators), one senior caregiver (apartment coordinator), 6 caregivers (three hospital, three rest home) and two activities and lifestyle coordinators, two chefs, two laundry assistants, one cleaner and one maintenance person staff described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident in all nine resident files reviewed: four rest home (including one serviced apartment), and five hospital (including one respite and one palliative care resident). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts.</p>

choices and give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files included information on the resident's family/whānau and chosen social networks. Complaint's resolution letters include a reference and information to advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed their understanding around visiting times. Visitors were requested to make half hour appointments (in line with the current Covid 19 guidelines) and observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with residents and relatives, confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being investigated and resolved in a timely manner. Complaints are recorded and allocated to a category All complaints evidence a consultation meeting with the complainant. The complaints process is linked to the quality and risk management system. Two complaints received in 2020 since the last audit and five complaints made in 2021 year to date have been managed in a timely manner and are documented as resolved. Complaints are categorised and are rated according to risk (low/medium/high and extreme). All complaints risk rated as high and extreme will be escalated to the regional operations manager.</p> <p>There was one letter on file from the Health and Disability Commissioner (HDC) dated 18 June 2021 confirmed closure of a case after referral from the coroner was made to HDC in 2019. The letter confirmed that all recommendations were met to close off the case.</p> <p>One complaint in June 2020 was referred to the HDC and the Ministry of Health requested follow up against</p>

		<p>aspects of the complaint that included:</p> <p>Communication with family regarding care concerns/deterioration, aspects of service delivery including care planning, monitoring and documentation related to nutrition (food and fluid), elimination support and supervision. There were no identified issues in respect of this complaint.</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. Five relatives (one rest home, four hospital) and six residents (four rest home and two hospital care) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support resident privacy and confidentiality. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors were closed while cares were being done. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences are identified during the admission and care planning process with family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Caregivers interviewed described how choice is incorporated into resident cares. Staff attend education and training on abuse and neglect, last completed in October 2021.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service has links with the local Māori iwi for advice and support as required. There was one resident who identified as Māori at the time of the audit. Cultural needs were addressed in the resident's care plan and recognise the effect of any decision on the resident's relationship with their family, whānau, hapū, iwi, and family group and their links to whakapapa to be considered. Staff completes annual cultural awareness education.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities, house rules and professional boundaries. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provides guidelines and mentoring for specific situations. Interviews with staff confirmed an 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 have been developed in line with current accepted best practice and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Any policy updates and changes are noted in the meeting minutes and staff are made aware of changes through the Ryman communication channel (ChattR). 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.</p> <p>Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the teamRyman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to improve practice and resident's outcomes based on the evidence provided (link 2.3.6.1 and 2.1.1.4).</p> <p>A number of core clinical practices also have education packages for staff, which are based on their policies. Registered nurses participate in the RN journal club, case study meetings which focused on improving clinical oversight, enhance clinical reasoning and improve critical thinking. Registered nurses also completed a three sessions of wound care management including recognising soft tissue infections, treatments of chronic wounds and pressure injuries and recognising systemic deterioration due to infections. There are quarterly wound champion webinars a year through Ryman academy to ensure good</p>

		<p>clinical practice and guidelines are followed.</p> <p>Ryman Christchurch continuously use complaints data and information to create a ` lessons learned` approach to education so all staff across all facilities can learn from complaints. Annual education sessions include ` Closing the loop` sessions which included recognising deterioration in a resident with possible sepsis /systemic infection (related to UTIs, wounds, catheters etc.), choking and swallowing issues, assisting residents with advanced directives, escalating and avoiding complaints, communication during and after complaints received including care of the complainant and open disclosure, management of nutrition and related issues (including weight loss, constipation, hydration), pain and respiratory deterioration.</p> <p>The service has been awarded a continuous improvement around implementation of the clinical oversight support model.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. Twelve incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted in a timely manner after adverse events or at any time the residents deteriorate. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed, for residents who are unable to speak or understand English. Registered nurses completed a clinical excellence training including communication with families after adverse events or deterioration of a resident. Communication to families related to Covid-19 is published on the Ryman website and individual emails are sent to relatives. Family members interviewed confirm they are updated with any changes in health of their relative and feel informed about the facility's strategy under the Covid 19 preparedness framework.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services</p>	FA	<p>Shona McFarlane is a Ryman healthcare retirement village. They are certified to provide rest home, hospital (geriatric and medical) care for up to 78 residents in the care centre. There are a further 20 serviced apartments that are certified to provide rest home level care. One rest home room in the care centre was decommissioned to include the current building of an extension to the care centre. The total</p>

<p>are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>bed numbers in the care decreased from 79 to 78.</p> <p>On the day of the audit there were 76 residents including four residents at rest home level care in the serviced apartments. The rest home unit has 38 beds with 36 occupied at rest home level of care. The hospital unit has 40 beds with 36 occupied at hospital level of care including one person on respite care and one on palliative care (support care contract). All other residents were on an age-related residential care (ARRC) service agreement contract. All 78 rooms in the care centre are dual-purpose beds.</p> <p>There is a documented service philosophy set at Ryman Christchurch that guides quality improvement and risk management in the service. In addition, a value statement, philosophy, goals, values, and beliefs are documented that are specific to Ryman Shona McFarlane. Five village objectives for 2021 (embraces initiative, effective leadership, vibrant and engaging programme, enhance quality of care and provide excellent dining room experience) are defined with evidence of reviews in April and August 2021 on progress towards meeting these objectives. Objectives and the progress towards meeting these objectives are posted in the staff room.</p> <p>The village manager (non-clinical) has been in the role for six months, previous experience in business management and hospitality. The village manager is supported by a clinical manager who has been in the role for three months and has experience in aged care in clinical management roles. They are supported by an assistant to the manager, three-unit coordinators, RNs, and caregivers. There are weekly management meetings. The village manager reports to the regional operations manager who reports to the operations manager.</p> <p>The village manager has maintained over eight hours annually of professional development activities related to managing an aged care facility. Training included conflict resolution, effective leadership, governance, and management of aged care services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical manager is responsible during the temporary absence of the village manager, with support from the assistant to the manager, regional operations manager, and Ryman management team.</p>
<p>Standard 1.2.3: Quality And</p>	<p>FA</p>	<p>Ryman Shona McFarlane continues to implement the well-established quality and risk management system</p>

<p><b>Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>that is directed by Ryman Christchurch. Quality and risk performance are reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff, and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities.</p> <p>Resident and relative meetings are held. Minutes are maintained with evidence of follow-up. Annual resident and relative surveys are completed with the last survey completed in August 2021, with improvements documented from the previous year around food services. Results are benchmarked against all Ryman facilities.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. All policies were current and reflect good practice and accepted guidelines. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality-of-service delivery in the facility and across the organisation. The service develops quality improvement plans where internal processes such as incident, infection control internal audit document an adverse result. Quality Improvement Plans (QIP) are documented as followed up, reported to meeting and resolved QIPs have included communication of laboratory results, management of urinary tract infections and soft tissue infections, decrease of rest home falls and working towards maintaining a restraint free environment. Six monthly trend analysis documented around falls, infection control, pressure injury and behaviours that challenge document in-depth analysis and follow-up.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and identify trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Health and safety policies are implemented and monitored. One health and safety officer was interviewed and confirm they completed external training related to work safe practices. The hazard register and hazardous substance register has been reviewed in August 2021. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events on an electronic system (Donesafe) and provides feedback to the service and staff so that improvements are made. There is monthly health and safety meetings, and the information is tabled at staff and management meetings. Staff completed annual education in emergency preparedness and health and safety issues including hazard identification in July and October 2021.</p>
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		The service has exceeded the standard around falls prevention.
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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, corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted, relative notification and any follow-up action required. There is a QIP in place to look at reducing the number of falls in 2021. A review of twelve electronic incident/accident reports for August 2021 were reviewed and identified that all were fully completed and included follow-up by a RN. Neurological observations are completed for unwitnessed falls and where there is an obvious knock to the head. The unit coordinators and managers review adverse events as part of the weekly management meeting.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. There were one section 31 notifications made in 2020 for a stage four pressure injury. In 2021 year to date six notifications have been made for four pressure injuries (one stage four and three stage three pressure injuries), one missing/wandering person and for a change in clinical manager. Notification has also been made to Public Health authorities for one outbreak (gastro) in August 2020.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Eleven staff files reviewed (village manager, clinical manager, two-unit coordinators (RNs), three caregivers (including health and safety officer), laundry assistant, one activities and lifestyle coordinator, one kitchen assistant and one chef) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN and other health professional practising certificates are maintained and current. An orientation programme provides new staff with relevant information for safe work practice.</p> <p>Staff need to be double vaccinated against Covid19 to commence or continue with employment.</p> <p>There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate. There are implemented competencies for RNs and caregivers related to specialised procedures or treatments including medication competencies, restraint minimisation, manual handling, and insulin competencies.</p> <p>There is a completed annual education plan for 2020 and the plan for 2021 is being implemented. The annual training programme exceeds eight hours annually. Additional toolbox sessions are provided. Registered nurses are encouraged to attend external training, including sessions provided by the local DHB, webinars via zoom. 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</p>

		<p>comprehension surveys each year. There are nine RNs working at Ryman Shona McFarlane and nine have completed interRAI training. There are 70 caregivers in total. Ninety percent of caregivers attained a level three of four national certificate in aged care. Caregivers confirmed they are supported to progress with their national certificate levels.</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 work Monday to Friday. The clinical manager works Sundays to Thursdays. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</p> <p>There is a receptionist to cover reception to manage Covid tracing and visits Monday – Sunday 8.30am-5 pm and again from 5pm- 7 pm.</p> <p>There were 36 rest home residents in the rest home unit (38 beds dual purpose).</p> <p>A rest home unit coordinator (RN) works from Thursday to Saturday (7.30am-4pm) and an RN covers on the two days that the unit coordinator is not available. One RN is rostered Monday to Friday 9 am to 1 pm. They are supported by four caregivers on the morning shift (7am-3pm, 7am-3.30pm, 7am-1.30pm, 7.30am-1pm), four caregivers (one senior) on the afternoon shift (two 3pm-11pm, one from 4pm-9pm and 5pm-8.30pm) and two caregivers (one senior) on the night shift working 10.45pm-7.15am and 11pm-7am.</p> <p>An activities and lifestyle coordinator Monday – Fridays from 9.30am-4.30pm and a second assist on Tuesdays and Thursdays (1pm-4.30pm)</p> <p>There were 36 hospital residents in the hospital unit (40 dual-purpose beds).</p> <p>A hospital unit coordinator (RN) works from Tuesday to Saturday (8am-4.30pm). There are two RNs on morning (7am-4.30pm) and afternoon shifts (one from 3pm-11pm and one from 3pm-11.30pm) one on the night shift. They are supported by eight caregivers on the morning shift (four long and four short), six caregivers on the afternoon shift (two long and four short) and two caregivers on the night shift. A fluid assistant and physiotherapy assistants work from 9.30 am to 1 pm and a lounge carer works from 4 pm to 8 pm.</p> <p>An activities and lifestyle coordinator Monday – Fridays from 9.30am-4.00pm.</p> <p>There were four rest home residents in the serviced apartments (20 beds). A serviced apartment unit coordinator/senior caregiver works from Sundays to Thursdays and a senior caregiver covers the two days that the unit coordinator is not available. They are supported by two caregivers (one senior) on the morning (one short and one long shift) and two on afternoon shifts (one long and one short). A RN from the rest home unit covers the rest home residents in the serviced apartments during the day and the hospital RN</p>

		<p>will cover residents in the rest home and service apartments during the afternoon and night.</p> <p>An activities and lifestyle coordinator Monday – Fridays from 9.30am-4.30pm</p> <p>Extra staff can be called on for increased resident requirements when acuity change. A cover pool has been implemented whereby (extra) care staff are scheduled to work Friday to Monday to cover absences. Additional casual staff are available if needed.</p> <p>There are separate housekeepers, laundry staff, van drivers, maintenance, and garden staff on the roster.</p> <p>Staff were visible and were attending to call bells in a timely manner as observed by the auditors during the audit. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support.</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. Staff have personal logins to access information. Resident information (hard copy and electronic) is protected from unauthorised access. Entries are legible and dated by the relevant care staff or registered staff, including their 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. The service has an information pack available for residents/families at entry including information on the 48-hour complimentary service for village residents, short-term stays, rest home, and hospital level of care services. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements and the one short-stay admission agreement for a respite resident were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. All appropriate documentation and communication were completed. Transfer to the hospital and back to the facility post-discharge was</p>

transfer from services.		well documented in progress notes.
<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 in place for all aspects of medication management, including self-administration. Registered nurses, and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely for all areas (hospital unit, rest home, and serviced apartments). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk imprest supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication room and fridge are checked daily, and temperatures sighted were within the acceptable range. There were two rest home residents and one hospital level resident self-medicating on the day of audit. Medications were stored safely in the residents' rooms. Three monthly self-medication competencies had been completed by the RN and authorised by the GP.</p> <p>There were no standing orders. There were no vaccines stored on site.</p> <p>Eighteen medication charts on the electronic medication system were reviewed and medication administration observed complied with policy. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The meals at Ryman Shona McFarlane are all prepared and cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence which expires 9 May 2022. There is a four-weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The 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. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily on the electronic kitchen management system which has oversight from the regional lead chef. Food temperatures are checked at all meals. These are all within safe limits. There are three dining rooms (one for the rest home, one for the hospital and one for the service apartment residents). Meals are transported from the kitchen in heated scan boxes and served from bain-maries in each wing's servery. Meals are served by care staff in the</p>

		<p>hospital wing and serviced apartment dining room. The chef and assistant cook rotate through the areas to assist with serving meals. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Care staff interviewed are knowledgeable regarding a resident's food portion size and normal food and fluid intake and confirm they report any changes in eating habits to the RN and record this in progress notes. Food services staff have all completed food safety and hygiene courses.</p> <p>The residents can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</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 24-48 hours of admission for all residents entering the service including the respite resident. InterRAI assessments had been completed in all long-term residents' files reviewed. Applicable assessments are completed and reviewed at least six-monthly or when there is a change to residents' health. The outcome of all assessments is reflected in the myRyman care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs, resident goals and provide detail to guide care. Care plans reviewed on myRyman have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, occupational therapist, and wound care specialist nurse. The care staff interviewed advised</p>

		<p>that the myRyman care plans were easy to access.</p> <p>Care plans include strategies to maintain a regular bowel elimination and include pharmacology, dietary including fluid requirements and non- dietary interventions such as maintaining good oral health, encourage mobility and exercise.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></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 RN initiates a GP or nurse specialist consultation. Registered nurses interviewed stated that they notify family members about any changes in their relatives' health status. Family members interviewed confirmed this. Conversations and notifications are recorded in the electronic progress notes. All care plans reviewed had interventions to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>The electronic myRyman system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident's room allows the caregiver to sign the task has been completed (e.g., resident turned, fluids given).</p> <p>Care staff interviewed stated there are adequate supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment and management plans are completed on myRyman. When wounds are due to be dressed, a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms and wound monitoring occurred as planned in the sample of wounds reviewed. There are currently six lesions, eight skin tears (six for one resident), six chronic ulcers, one surgical and one classed as other. There is one stage 4 pressure injury (non-facility acquired), two stage 3, and one stage 2 pressure injuries (facility acquired) which have been reviewed by the wound nurse specialist and wound champion. The wound champion nurse reviews all wounds at least monthly in addition to ongoing review by the RN on duty. Pressure injury prevention equipment is available and being used. Caregiver's document change of position electronically.</p> <p>Short-term care plans are generated through completing an updated assessment on myRyman and interventions are automatically updated into care plans. Evaluation of the assessment when resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as: weight; food and fluid; vital signs; blood sugar levels; neurological observations; wound monitoring; bowel and behaviour charts. The RNs review the monitoring charts daily. All monitoring charts reviewed, including bowel, food and fluid records had been completed as per policy requirements.</p> <p>RNs interviewed confirm management of constipation is based on the individual's comorbidities,</p>

		<p>characteristics of stool including overflow and individual response by creating toileting schedules and dietary (adequate food and fluid intake), medication reviews by the GP and close supervision to maintain regular toileting habits. Care staff report any deterioration or change in normal habits to the RN.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A team of five activity and lifestyle coordinators (one a qualified DT) implement the 'Engage' activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The programme is overseen by a group diversional therapist at Ryman head office. The rest home programme is Monday to Friday and the hospital is seven days a week, which includes evening activities between 4.30pm and 8pm.</p> <p>There is a monthly programme for each unit, delivered to each resident's room. A daily activity programme is written on the lounge whiteboard. Residents have the choice of a variety of Engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home resident in the serviced apartment can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The village has a van available for the weekly outings and hires a wheelchair accessible minibus to cater for those residents who cannot access the village vehicle safely. There are regular combined activities and celebrations held in the ground floor lounges for residents from both areas.</p> <p>During Covid-19 lockdown, the service-initiated 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 various denominational church services held in the care facility weekly. There are regular entertainers visiting the facility. Special events like birthdays, St Patricks day, Matariki, Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Of the nine resident care plans reviewed, six had been evaluated by the registered nurses six monthly or when changes to care occurs (two were recent admissions and one was a short-term respite). The RN completes a daily evaluation for the short-term respite resident. The multidisciplinary review involves the</p>

<p>comprehensive and timely manner.</p>		<p>RN, GP/NP, caregiver, and resident/family if they wish to attend. Resident progress towards meeting goals is discussed and documented. 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 consulted/informed regarding any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, geriatrician, mental health services for older people, and dietitian. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety 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.</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 warrant of fitness that expires 8 March 2022. The facility employs a full-time maintenance officer, gardens, and grounds staff. Daily maintenance requests are addressed, and a 12-monthly planned maintenance schedule is in place and has been signed off monthly (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment, this is next due August 2022. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment.</p>



		<p>Residents were observed moving freely around the areas with mobility aids, where required.</p> <p>There is outdoor furniture and seating with shade in place, and there is wheelchair access to all areas. Residents were observed safely accessing the outdoor gardens and courtyards. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The care centre consists of a rest home wing (Sunflower) 38 beds and a hospital wing (Tulip) with 40 beds (dual purpose), each with its own nurse's station. The 20 service apartments certified for rest home care are easily accessible and adjacent to the care centre. There were three rest home residents in the upstairs service apartments and one downstairs. There are stairs and a lift (spacious enough for ambulance transfer equipment).</p> <p>One rest home room in the care centre was decommissioned in July 2021 to include the current building extension to the care centre to include a new reception area with administration offices, rest home lounge and café. The number of care beds in the rest home (dual purpose) then decreased from 39 to 38 and the total number of care beds in the care centre decrease from 79 to 78 in total. The work has already started. Temporary internal plywood partitions/walls separate the construction site from the rest of the rest home , and dust and noise are mitigated by the construction of these plywood partitions. The entry and exit to the facility and freedom of movement of the residents within the facility are not impacted. There is a separate entry to the construction site and hazards are identified on a board at entry , the site is cordoned off on the outside of the building but does not impact the main entrance or parking.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms within the facility have ensuites. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are mobility toilets near all communal lounges. There are privacy signs on all toilet doors.</p>
<p>Standard 1.4.4: Personal</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Staff interviewed reported that rooms have sufficient space to allow cares to</p>

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>take place and the rooms are large enough for family and friends to socialise with the resident. Residents are encouraged to bring their own pictures, photos, and furniture to personalise their room, as observed during the audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are several lounges throughout the facility and a dining room in each area. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. The lounges and dining areas are large enough to cater for activities. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. There are quiet areas if residents wish to have some quiet time or speak privately with friends or family</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>	FA	<p>All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaners’ trolley sighted were labelled. The sluice rooms and the laundry are kept locked when not in use. Cleaning and laundry staff interviewed could accurately describe the policies and processes around infection control as they related to their roles.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan (1 June 2001) and has not been amended since. Fire evacuation drills are completed every six months, last completed 3 August 2021. Smoke alarms, sprinkler system and exit signs are in place. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Civil defence and pandemic supplies are checked monthly as part of the preventative maintenance plan. The facility has back-up lighting, power and sufficient food and personal supplies to provide for its maximum number of residents in the event of a power outage and portable gas heaters would provide alternative means of heating. Training in civil defence and emergency preparedness including fire warden training occurred in October 2021. There is sufficient water stored to ensure for twenty litres per day for seven days per resident. There are alternative cooking facilities available with a gas barbeque. The facility has its own generator. There is a resident evacuation list, emergency flipcharts, emergency contact lists. In the case of</p>

		<p>residents requiring to be evacuated, there is an agreement in place within Ryman to accommodate and assist with relocation etc. There is at least one staff member on each shift with a current first aid certificate.</p> <p>There is a contracted security company to conduct security patrols. Staff complete security checks on the afternoon shift. The main door is automated and closed at night and external doors are alarmed.</p> <p>There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas (including service apartments). Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility utilises wall heaters, all of which are thermostatically controlled. All bedrooms and communal areas have at least one external window.</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>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is the clinical manager. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets monthly. The programme is set out annually from Ryman Christchurch and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers. On the day of audit, Shona McFarlane was operating effectively under Covid19 preparedness and prevention traffic light guidelines.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff received vaccinations and the Covid 19 vaccination status are requested at entering the facility. Hand sanitisers are placed appropriately within the facility. Visitors and staff are required to wear the masks provided.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>The infection prevention and control committee (combined with the health and safety committee) meet monthly. The infection control officer is the clinical manager is allocated time each month to collate infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections. The infection and prevention officers have access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory, and expertise from within the Ryman Christchurch team.</p>

<p>infection control programme and meet the needs of the organisation.</p>		<p>Ryman Covid-19 strategies have been implemented within the facility. There are robust processes documented and include a full monthly stocktake of personal protective equipment (PPE). The result of the stocktake are sent to the offsite Ryman warehouse in Christchurch which ensures PPE stocks are replenished. Staff were observed practicing good hand washing techniques.</p> <p>Staff received updates related to Covid preparedness through the internal communication channel (ChattR) that is available on the dashboard and as an application from their phones. Covid preparedness drills are conducted weekly or monthly dependant on the level of Covid 19 risk.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<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. Covid 19 prevention strategies and risk management plans are part of the overall infection control prevention programme.</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>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to all staff, and she has attended external training for her role. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda. There is regular education around Covid outbreak management to ensure staff are fully aware of protocols when lockdown levels change.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection prevention 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 and are displayed on the staff noticeboard. The infection prevention and control programme links with the quality programme including internal audits and education requirements. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. There was a gastro enteritis outbreak in August 2020 that affected 15 residents across the service (no staff) which was well managed and appropriately reported.</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 only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents using restraints and none using enablers. Staff training has been provided around restraint minimisation and enablers, falls prevention and management of challenging behaviours. The service implemented a QIP in early 2020 to work towards a restraint free environment and interventions proved to be successful.</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

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Ryman Christchurch implemented and piloted the clinical oversight support model at Shona McFarlane Retirement Village where usual support processes are not effective in addressing the clinical needs identified at the specific village. Shona McFarlane was chosen to support them through two complaints risk rated as extreme, the number of quality improvement processes identified related to the clinical data. The village team are responsible to review their own clinical indicators. The model aims at growing the clinical oversight of the village team by improving resident outcomes. It aims further to provide ongoing support by reducing clinical risk, restore trust relationships and improve team culture.</p>	<p>There were initial onsite visits from the Ryman auditing team for a couple of days. There are weekly clinical meetings with the leadership team including a clinical advisor, senior informatics nurse manager, clinical advisor wound care specialist, clinical advisor training and projects, clinical operations manager, and operations clinical coordinator. The team follows a structured approach related to investigating internal audit outcomes, identifying education attendance and needs, auditing of systems including resident files and clinical data including falls, complaints, wounds, infections to identify gaps in clinical management and service delivery and provide weekly tasks and goals to the village team to complete, this will be reviewed at the next meeting.</p> <p>The village manager, clinical manager and unit coordinators interviewed confirm the support provided developed their skills to identify clinical issues early and be proactive, and improve on clinical indicators through best practice, early assessments, and timely</p>

			<p>referral. A total of twenty meeting minutes were reviewed. There were a lot of action points in the beginning and hardly any action points in the later meeting minutes. The regional operations manager interviewed expressed satisfaction that the model to be extremely effective. Shona McFarlane Retirement Village clinical indicator data improved which evidenced successful clinical oversight and improved resident outcomes since the implementation of the model. Shona McFarlane Retirement Village is now restraint free (link 2.1.1.4), behaviours that challenge continues to decrease, falls management strategies are effective to reduce falls (link 1.2.3.6), the period towards progression of more complex wound healing reduced from average of 54 days to 18 days (pressure injury healing reduced from average 106 days to 19.4 days), and number of bruises are consistently under 6.0/1000 (lower than target rate) occupied bed nights since August 2020.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Robust systems are in place for the collection, analysis, and evaluation 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, and data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management, full facility, and clinical/RN meetings). Templates for all meetings document action required, timeframe, and the status of the actions.</p> <p>Falls are discussed at the leadership meetings, with fall prevention strategies reviewed, and the residents' underlying conditions considered. The falls assessment tool is completed, and falls protocols are monitored and followed up post falls. The clinical manager reviews the call bell</p>	<p>Falls in the rest home unit were identified as an area that required improvement from data collected from 2020. A continuous improvement plan was developed in June 2020 which included identifying residents at risk of falling, reviewing call bell response times, routine checks of all residents specific to each resident's needs, intentional rounding including toileting regimens for identified high risk fallers, staff complete education to heighten their awareness of residents with falls risk through completion of competencies in falls prevention, reviewing the roster to ensure adequate supervision of residents, the use of sensor mats, proactive and early GP involvement for residents post falls and review of underlying causes for falls including medication optimisation.</p> <p>The plan has been reviewed monthly and discussed at management and clinical meetings, with fall prevention strategies reviewed and the residents' underlying conditions considered. Education and training for staff has been provided on manual handling, safe transfers, falls prevention strategies including effective pain management, continence, and toileting schedules, managing distressed behaviour, and promoting nutrition/hydration. Pain management plans are comprehensive and non-pharmaceutical interventions are considered including exercises. Caregivers were involved in creating strategies to</p>



		<p>report, and copies are provided to the unit coordinators. The physiotherapist reviews changes in resident mobility and a physio assistant ensures instructions and exercises are followed. Lounge assistants monitor residents in the lounge and provide de-escalation. Residents at risk of falling are encouraged to join the exercise programme. Care plans provide documented evidence of effective pain management strategies that include non-pharmaceutical interventions. Falls and incidents are discussed at the handovers between shifts to ensure staff are up to date with current information.</p>	<p>prevent falls. Caregivers interviewed were knowledgeable regarding preventing falls and those residents who were at risk. The outcome of the plan has been that rest home falls rates between July 2020 and November 2021 were below 3.0/1000 occupied bed nights and below the group rate for falls. There were two spikes in the graph in December 2020 and May 2021 and this was related to two individuals with ill health. This continues to reduce with the current rate (December 2021) being below 3.0/1000 occupied bed nights.</p> <p>The resident survey for 2021 ratings for care delivery and communication have increased and consistently above the target range of 4.0. Positive feedback from residents and relatives around care were noted. Residents interviewed confirm they are supported to maintain their independence.</p>
<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 indicated Shona McFarlane Retirement Village to be restraint free since September 2020. The unit coordinators, clinical manager and village manager interviewed confirm that a range of initiatives are implemented to ensure the restraint free environment is maintained. Meeting minutes reviewed evidence 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. This includes:</p> <p>Individual strategies to respond to specific resident needs including falls prevention, early intervention to identify changes in behaviour, quality use of medication, safe environment, 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 to promote residents' independence through mobility support and exercise, lounge carers oversee residents in the lounge area to assist with supervision, activities and de-escalation where required, and fluid assistants to ensures residents are adequately hydrated. Education sessions for staff were provided to include dementia related training, restraint minimisation practices and management of challenging behaviours. This resulted in an increased understanding of the importance of early intervention, encourage staff input into residents' cares and empower staff through accountability. Ongoing communication and involvement of the next of kin and with residents improved an understanding of the</p>

			<p>Ryman strategy to maintain a restraint free environment.</p> <p>The strategies allow for early interventions of distressed behaviour. Staff aim to understand the unmet need, identify trends in times or locations, and incorporate this into the care plans. Pain management includes non-pharmaceutical interventions and medication optimisation ensures cognitive abilities are supported. The data evidenced the service maintained the restraint free environment since the start of the initiative with no incidences of restraint or enablers reported. Quality data related to incidence of challenging behaviour per 1000 occupied bed days has decreased between January 2021 and November 2021 in the hospital from 98.4 to 8.5. The resident survey for 2021 ratings for care delivery and communication have increased and consistently above the target range of 4.0. Positive feedback from residents and relatives around care were noted. These findings were discussed at the upcoming clinical and quality meetings and monthly residents' newsletters.</p>
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End of the report.