

Charles Fleming Retirement Village Limited - Charles Fleming 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Charles Fleming Retirement Village Limited
Premises audited:	Charles Fleming Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 February 2019 End date: 5 February 2019
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:	119



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

Charles Fleming Retirement Village is a Ryman Healthcare facility. The facility provides rest home, hospital (geriatric and medical) level and dementia level of care for up to 120 residents in the care centre and up to 20 rest home residents in the serviced apartments. At the time of the audit, there were 119 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 included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and general practitioner.

The village manager is suitably qualified and supported by a clinical manager and an assistant village manager. The management team is supported by the Ryman management team including the regional manager.

The previous finding around care plan interventions remains an area for improvement. There were no further areas requiring improvement identified at this audit.

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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Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Relative meetings for each unit is held regularly. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The quality and 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 implemented for new staff. Ongoing education and training includes in-service education and competency assessments. Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care plans demonstrate service integration, and are individualised and evaluated six-monthly. The resident/family/whānau interviewed confirmed they are involved in the care plan process and review. The diversional therapists and activity coordinators provide an Engage activities programme in each unit. The recreational needs of the residents are met through a varied and interesting programme with the families and community. There are 24-hour activity plans for residents in the dementia care unit that is individualised for their needs. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three-monthly GP medication reviews. Meals are prepared on-site. The menu is designed by a dietitian at organisational level and provides menu options. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with enablers and two residents with restraints at the time of the audit. Assessments, consent forms and the use or risks associated with the restraint were evidenced. 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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	1	0	0
Criteria	0	40	0	0	1	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 Charles Fleming facility. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and regional 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 seven complaints made in 2018 and one complaint received in 2017 since the last audit. Complaints have been acknowledged and addressed within the required timeframes. The complaint made in 2017 was made through the district health board (DHB). The service completed internal investigations relating to hot temperatures and staffing ratio in the dementia unit with no further action required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an incident reporting policy that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Twelve incident forms reviewed evidenced the family had been informed of the accident/incident. Five relatives (two rest home, two hospital and one dementia care) interviewed, stated that they are informed when their family members health status changes. Six monthly relative meetings occur in each of the units (rest home, hospital and dementia care). Five residents (four rest home and one hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident</p>

conducive to effective communication.		should they wish to do so. Interpreter policy and contact details of interpreters is available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Charles Fleming is a Ryman retirement village located in Waikanae. The service provides care for up to 120 residents at hospital, rest home and dementia level care and 20 serviced apartments certified for rest home level of care. On the day of audit there were 119 residents in total, 40 of 40 rest home residents including one resident on respite care on level one, 40 of 40 hospital level residents on level two, 36 of 40 dementia care residents on level three, including one resident on a long-term support chronic health condition (LTS-CHC) contract and one resident on respite care, and three of 20 rest home level of care residents in the serviced apartments on level one.</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 2019 and progress towards objectives is updated as part of the teamRyman schedule.</p> <p>The village manager at Charles Fleming is non-clinical and has been in the role for four years. She is supported by a clinical manager who has been in the role for one year and an assistant village manager. The village manager is also supported by a regional manager.</p> <p>The village manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Charles Fleming 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 the management team (village manager, assistant manager and clinical manager) and staff, and review of meeting minutes demonstrate their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Annual resident and relative surveys are completed, last in February 2018. Results and any areas for improvement are fed back to staff and participants through resident and relative meetings. There has been an increase in the resident overall satisfaction rate from the previous year, hospital residents increased to 4.27 average score (5 being the highest rating) from 4.02 and rest home residents increased to 4.13 average score from 4.02.</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</p>

		<p>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 this, the hazard register, and the maintenance register indicate that there is resolution of issues identified. Falls prevention strategies are in place that include; ongoing falls assessment, reviewing call bell response times and routine checks of all residents specific to each resident's needs (intentional rounding).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of 12 incident/accident forms for January 2019 and December 2018 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 six 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 has been one section 31 notification since the last audit for a stage three pressure injury in August 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	FA	<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 RN, three caregivers including the health and safety officer and one head chef) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN, EN and health professional practising certificates are maintained and current. An orientation/induction programme provides new staff with</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>relevant information for safe work practice. There is a completed annual education plan for 2018 and the plan for 2019 is being implemented. Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session.</p> <p>Additional toolbox sessions are provided. There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate. Registered nurses are supported to maintain their professional competency. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. There are currently 17 RNs working at Charles Fleming and 10 RNs have completed interRAI training. Eighteen caregivers work in the dementia unit, 15 of 18 caregivers have completed their dementia standards. The three caregivers are in the process of completing their dementia standards have all commenced work within the last 18 months. A QIP is in place to ensure that the training is completed.</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. A plan of action document is available for staff around any weekly staff changes. The village manager works Monday-Friday and the clinical manager works Tuesday-Saturday. Both are on call 24/7 for any operational and clinical issues respectively. They are supported by three-unit coordinators/RN in the rest home, hospital and dementia units and one-unit coordinator/enrolled nurse (EN) in the serviced apartments. Interviews with five caregivers (one hospital, one rest home, two dementia care and one serviced apartment) stated the RNs are supportive and approachable. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs.</p> <p>Staffing at Charles Fleming is as follows; in the rest home unit there are 40 of 40 residents, there is a unit coordinator/RN on duty on the morning shift. There are four caregivers (two full and two short-shifts) on the morning and afternoon shifts and two caregivers on night shift. In the hospital there are 40 of 40 residents, there is a unit coordinator/RN who is supported by two RNs on duty on the morning and afternoon shifts, and one RN on night shift. There are seven caregivers (four full and three short-shifts) and a fluids assistant on morning shift, six caregivers (two full and four short-shifts) and a lounge carer on afternoons and three caregivers on night shift.</p> <p>In the dementia care unit there are two 20 bed units. There is a unit coordinator/RN who is supported by an RN on duty on the morning and afternoon shifts covering both units. There were 18 of 20 residents in both the 20 bed units. In each unit there are two caregivers (one full and one short-shift), a lounge carer covering both units on the morning shift, two caregivers (one full and one short-shift), a lounge carer covering both units on the afternoon shift and one caregiver on night shift (an additional caregiver floats between both units). The hospital RN covers the rest home unit on the afternoon and night shifts and the dementia unit on the night shift. At the time of the audit there was sufficient and experienced care staff available for 36 dementia residents in total (link 1.1.13).</p> <p>In the serviced apartments there are three rest home level residents, there is a unit coordinator/EN on the morning shift from Tuesday to Saturday and a senior caregiver on Sunday and Monday. There are two caregivers on the</p>

		<p>morning shift and two caregivers on the afternoon shift. The caregivers and RN from the rest home cover the serviced apartments on the night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet MOH guidelines. Medication reconciliation of monthly blister packs is completed by two RNs and the pack signed and dated. Any errors are fed back to the pharmacy. Registered nurses, enrolled nurses and senior caregiver who administer medications have been assessed for competency. Education around safe medication administration has been provided. The service uses an electronic medication system. Care staff, RNs and enrolled nurse interviewed could describe their role in regard to medicine administration. There were no residents self-medicating. Medications were stored safely in all four units (rest home, serviced apartments, hospital and dementia care).</p> <p>There is a bulk supply medication available for hospital residents. Medication fridges are monitored daily. All eye drops and creams in medication trolleys were dated on opening. Fourteen medication charts were reviewed across all units on the electronic medication system. All medication charts had photographs, 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>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by two other chefs, and a team of kitchen assistants to prepare and deliver the project "delicious" menu to the units. Staff have been trained in food safety and chemical safety. Project "delicious" provides daily menu options. Menu choices are decided by residents (or staff if the resident is not able), and offer a choice of three main dishes for the midday meal and two choices for the evening meal including a vegetarian option. The head chef receives dietary profiles for each resident and is notified of any dietary changes. Resident dislikes are mostly accommodated through the menu options however alternatives are provided if required. Diabetic desserts, pureed meals, food allergies and gluten free diets are accommodated. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Meals are delivered in hot boxes and served from bain maries in the unit kitchenettes.</p> <p>Serving temperatures are taken daily. Nutritious snacks are available 24 hours and include fruit platters, fingers foods, yoghurts and home baking delivered daily to the dementia care units. The head chef confirmed additional fluids are being provided including lemonade and ice-blocks for all units. Unit fridges viewed had many jugs of fluid available. The food control plan has been verified and expires 23 July 2019. Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Cooked and cooling temperatures are conducted on all main dishes. The chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents can provide feedback on the meals through resident meetings, survey and direct contact with the food services staff.</p>

		Residents and relatives interviewed spoke positively about the choices and meals provided.
<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>	PA Moderate	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the RN initiates a review and if required a GP visit or nurse specialist consultant. Pain management plans and pain monitoring charts were in place for two resident files reviewed with chronic pain. Repositioning charts were in place for residents with pressure injuries and those at high risk of pressure injuries. This is an improvement on previous audit. However, not all myRyman care plans for long-term residents reflected the required supports to meet all the resident's current health status. The previous finding around interventions remains. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver and RN to complete. Monitoring charts such as reposition charts, fluid charts, neurological observations, weight charts, blood sugar levels and pain monitoring charts and behaviour charts are well utilised. There is a lounge carer in the hospital and dementia care units whose role is to ensure all residents receive adequate hydration including ice-blocks.</p> <p>Wound assessments, treatment and evaluations were in place for a sample of 16 residents with wounds that were reviewed (10 hospital, five rest home and one dementia care). Wound assessments and management plans are completed on myRyman. There are four hospital residents with facility acquired pressure injuries (one stage one, two stage two and one stage three). There is one dementia care resident with stage two pressure injury of the heel. The wound champion reviews all wounds weekly. When wounds are due to be dressed a task is automated on the RN daily schedule. There was a shortfall around documented pressure injury prevention for two residents with pressure injuries. The GP reviews wounds regularly and there is access to a wound nurse specialist if required.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture,</p>	FA	<p>There is a team of activities staff (three with diversional therapy qualifications and activities coordinators who coordinate and implement the Engage activities programme across the rest home from Monday to Friday, hospital unit from Monday to Sunday, and dementia units from Monday to Sunday. Rest home residents in serviced apartments can choose which programme they would prefer to attend. The rest home and hospital programme have activities such as entertainment, celebrations and other activities that is open to all other residents to attend including dementia care residents (as appropriate and under supervision). 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 including Triple A exercises, themed events and celebrations, baking, sensory activities, musical moments, making memories, outings and drives.</p>

<p>and the setting of the service.</p>		<p>A facility van is available for outings for all residents. The lounge areas have seating placed for large and smaller group activities. One-on-one activities occur as well as regular wheelchair walks out in the gardens. Daily contact is made with residents who choose not to be involved in the activity programme. Community visitors include canine therapy, entertainers, school children and church groups. There are special interest groups including a men's club. The DT in the dementia unit is supported by caregivers to implement small group and individual activities for the residents across the two units. Meaningful activities include baking, walks, gardening and household activities. There are group activities, entertainment and men's club. There are twice weekly van outings with all residents having the opportunity to go out for scenic drives and outings. The unit has a shopping trolley where residents can choose from the trolley without monetary exchange. The outdoor deck of both units can be freely accessed by all residents.</p> <p>The outdoor areas have been upgraded with new furniture, wall art and raised gardens with edible foods such as tomatoes and herbs. Residents take an interest in watering and tending to the gardens. Activity assessments are completed for residents on admission. The activity plan in the electronic files reviewed for long-term residents had been evaluated at least six-monthly with the care plan review. The resident (as appropriate)/family/whānau are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident and relative meetings and satisfaction surveys. Residents interviewed spoke positively about the programme. Activities staff attend on-site and organisational in-services relevant to their roles. The designated bus driver holds a first aid certificate. In two dementia level myRyman files reviewed, all the information around activities to engage or distract residents over the 24-hour period were documented throughout the care plans in various sections.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Electronic resident files reviewed identified that long-term care plans had been evaluated by RNs at least six-monthly or earlier as required. Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review.</p> <p>There is also a multidisciplinary (MDT) review completed that includes people involved in the resident's care. Records of the MDT review were evident in the long-term resident files reviewed. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 10 March 2019. The maintenance team address any maintenance requests or call in contractors as required. There is a planned maintenance schedule in place. New air conditioning units have been installed in the dementia units. A relative of one of the dementia residents</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>interviewed stated that the dementia unit was cooler now with the new air conditioning units installed (link 1.1.13). The deck areas and gardens have been upgraded with a shade sail in place.</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 resident files. Infections are included on an electronic register and the infection prevention officer (clinical manager) completes a monthly report. Monthly data is reported through all facility meetings and information including graphs and corrective actions are available in the staff room. The infection prevention and control programme links with the quality programme. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit there were no residents using enablers and two hospital residents with restraint in use (bedrails). Assessments, consent forms and the use or risks associated with the restraint were evidenced in the two resident files reviewed. Staff training has been provided around restraint minimisation and enablers, last occurring in December 2018.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Wound assessments, plans and evaluations are completed at each dressing change and recorded in the myRyman system. Wound care documentation was being maintained for all current wounds and pressure injuries, but the interventions were not reflected in the care plans. There were no interventions documented for one resident with seizures.</p>	<p>i) Two resident myRyman care plans (one hospital and one dementia care) did not reflect pressure injury interventions for current pressure injuries.</p> <p>ii) There was no seizure management plan for one dementia care resident (LTS-CHC) with recent seizures requiring 'as required' medication.</p>	<p>Ensure care plans reflect interventions to support the residents' current health needs.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.