

Bob Owens Retirement Village Limited

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:	Bob Owens Retirement Village Limited
Premises audited:	Bob Owens Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 December 2014 End date: 2 December 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	122

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
	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
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ryman Bob Owens provides rest home, hospital and dementia care level of care for up to 120 residents in its care centre. On the day of audit there were 39 rest home, 39 hospital and 39 dementia care residents. There are also 79 apartments on site of which 30 beds are approved to provide rest home level care in the serviced apartments. On the day of audit there are 5 rest home residents in the serviced apartments.

The non-clinical village manager has been in the role since January 2014 and is supported by an experienced registered nurse/clinical manager who has been in the role since April 2014. Management and staff are committed to continuous improvement. Health and safety and infection control is well embedded into practice. There are sufficient staff on duty to meet the resident needs at both rest home, hospital and dementia level of care. There is a comprehensive orientation programme for all new staff.

Two of four shortfalls from the previous audit relating to job descriptions and medication have been addressed. Two previous shortfalls around general practitioner (GP) admissions and documentation of altered behaviour continue to require improvement. This audit identified further areas for improvement around aspects of training, restraint, interventions, evaluations and activity plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies are implemented to support residents' rights which include ensuring staff communicate with residents and relatives in an appropriate manner that respects the rights of residents. Staff practice open disclosure. Complaints processes are implemented and complaints and concerns are actively managed and well documented.

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.		Some standards applicable to this service partially attained and of low risk.
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The village manager has been in the role since January 2014. He has experience in business and human resource management. He is supported by an experienced clinical manager who has been in the role since April 2014. Both completed management orientation and receive support from the Ryman management team. Bob Owens participates in the Ryman accreditation programme, which is overseen by head office. There are facility specific quality objectives for 2014. Staff are guided by a range of policies and associated procedures. Human resource practices are overseen by head office. There are signed documented job descriptions. This is an improvement since the previous audit.

There is a comprehensive orientation and induction programme in place. A training plan for 2014 includes mandatory training and relevant clinical care. There is an improvement required around staff attendance at mandatory training and completion of dementia unit standards for staff employed in the dementia care unit.

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 low risk.</p>
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Initial assessments and risk assessment tools are completed by the registered nurse on admission. The facility is using electronic files and transitioning towards a paperless clinical file system. Care plans and evaluations are completed by the registered nurses. An improvement is required around evaluation timeframes. The resident/family/whanau interviewed confirmed they are involved in the care plan process and review. Short term care plans are in use for changes in health status. There are improvements required around progress notes, documentation of interventions, reviewing of falls risk, neurological observations, weight recordings and aspects of wound care evaluations.

The activity coordinators provide separate activity programmes for rest home, hospital and dementia care units that ensures the abilities and recreational needs of the residents is varied, interesting and involves the families and community. Twenty four hour activity plans are utilised for residents in the dementia care unit. There is an improvement required around the ensuring the activities plan is reflective of the resident's current recreational and health status, completing activities plans for all residents and review of activity plans at the same time as care plans.

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. There is an improvement required around ensuring that all residents have been admitted by the GP.

Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. 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 service displays a current building warrant of fitness.

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.		Some standards applicable to this service partially attained and of low risk.
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There are policies and procedures that meet the restraint minimisation and safe practice standards. Restraint use is used as a last resort. Restraint is discussed at registered nurse (RN), staff and management meetings. There is restraint education at orientation

and ongoing. There are five residents with restraints and no residents with an enabler. There is an improvement required around the review of restraint assessments and monitoring documentation.

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 prevention and control programme is managed by the infection control coordinator who is a registered nurse.

The surveillance programme is included in the Ryman accreditation programme, which is reviewed annually. An individual infection report form is completed for each infection. Monthly infection control data is entered onto the electronic system. Data information is available to all staff and is discussed at staff meetings. Infection rates are benchmarked against other Ryman facilities. Improvements are identified, implemented and evaluated.

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	10	0	6	0	0	0
Criteria	0	34	0	7	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has in place a complaints policy and procedure that aligns with Right 10 of the Code of Health and Disability Consumers' Rights (the Code). Complaints management is an integral part of the quality and risk management system. A complaints register is maintained and shows investigation of complaints (verbal and written), dates and actions taken for resolution. Complaints are also documented on the electronic system. Staff receive ongoing education on consumer complaints management and consumers rights.</p> <p>D13.3h: Information on the complaints process was provided to residents and relatives at entry to the service. The procedure and complaints forms were available around the facility.</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>Staff actively promote effective communication with residents in accordance with Ryman's values and policy (confirmed in discussions with eight residents and three relatives). Information was provided on entry and open disclosure is practiced. Staff receive ongoing education regarding open disclosure. Resident meetings are held two monthly and relative meetings six monthly.</p>

		<p>D12.1 Non-Subsidised residents have been advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” has been provided to residents on entry.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b. Three relatives stated that they were always informed when their family members health status changes.</p> <p>D 13.3. The admission agreement contains a schedule of fees and charges where applicable.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ryman Bob Owens provides rest home, hospital and dementia care for up to 120 residents. On the day of audit there were 39 rest home residents, 39 hospital residents and 39 dementia care residents. There are 79 serviced apartments of which 30 beds are approved for rest home level of care. On the day of audit there were five rest home residents in serviced apartments.</p> <p>Ryman Healthcare is governed by a Board of Directors. The CEO and senior management work from head office providing support for management.</p> <p>Ryman Healthcare's overall mission is defined in the Ryman Healthcare philosophy document. Ryman Healthcare has an organisational total quality management plan (2014). Bob Owens has specific village objectives set for 2014 which are regularly reviewed.</p> <p>The village manager (non-clinical) was appointed in January 2014 with a background in business and human resource management. The clinical manager (registered nurse) was appointed in April 2014 and has worked in a variety of roles including clinical management, quality and service delivery. Both have completed a comprehensive orientation. An assistant manager has been recruited by head office and will commence on 1 December 2014.</p> <p>D17.4 (b) (i), D17.5: The village manager and clinical manager have completed at least eight hours annually of professional development related to managing a hospital.</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>	<p>FA</p>	<p>Bob Owens has a well-established quality and risk management system that is directed by head office and documented in the Ryman Accreditation Programme (RAP). Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Annual resident and relative surveys are completed. Results were benchmarked against other Ryman facilities which showed significant improvement in service delivery at Bob Owens. The service complies with the monthly internal audit programme. Quality improvement plans (QIP) are raised as a result of identified shortfalls. Benchmarking occurs throughout Ryman facilities</p> <p>D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements. There is an effective document control system in place.</p> <p>D19.2g: Fall prevention strategies are in place.</p> <p>D19.3 There are implemented risk management, emergency management and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.4 (d): Performance is monitored and evaluated against the RAP including satisfaction surveying, internal and external quality reviews.</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>	<p>FA</p>	<p>All adverse events are recorded in accordance with the accident/incident reporting policy and reported according to policy. Data was entered into electronic system. Incident /accident forms sighted in residents' clinical records were fully completed and follow-up was documented. Improvements were made to the service as and where appropriate. Quality improvements were developed to implement improvements. Adverse events are linked to the organisation's benchmarking programme.</p> <p>Staff can describe the incident reporting process and their role.</p> <p>D19.3b: There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing.</p> <p>D19.3c Management is aware of their reporting obligations to report serious adverse events to the relevant agencies (confirmed in discussion with the clinical manager). The service experienced two outbreaks in 2014 (February and November). Notifications to the district health board were sighted for both significant events.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Human resource policy and practices are overseen by head office staff and senior management. A review of nine staff employment records identified that employment records were consistent with Ryman policy. There are signed documented job descriptions in all nine files. This is an improvement since the previous audit.</p> <p>All health practitioners hold current professional qualifications.</p> <p>All newly appointed staff received a comprehensive orientation/induction programme that provides them with relevant information for their role. The programme is tailored specifically to each job position. The service has an education officer and internal assessor that are allocated two days per week to work with students towards their qualifications. Improvements are required around staff training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The facility is staffed according to policy with flexibility to match resident acuity. The policy identifies the rationale for determining staffing levels and skill mix for safe service delivery.</p> <p>D17.4a-d: The rest home unit has a registered nurse seven days a week on morning shift. There are two RNs on morning and afternoon shifts in the hospital and on night shift. The hospital RN oversees the dementia care unit. The team of registered nurses are supported by the clinical manager who is employed full-time and is available on call.</p> <p>Residents, families, registered nurses and caregivers interviewed report sufficient staffing.</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>	<p>FA</p>	<p>The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. The service uses individualised medication blister packs for regular medications and as required medications. Medication packs were checked against the medication chart on delivery by a registered nurse and has been recorded. Three medication rooms were viewed (rest home, hospital and special care unit) and one medication cupboard (serviced apartments). All medications rooms are secure. Medications trolleys are locked. Contents are all within expiry dates and eye drops were dated on opening. Expiry dates of all</p>

		<p>medications were checked monthly. There is a specimen signature list of all medication competent persons. Caregivers or registered nurses administer medications in the serviced apartments, rest home and special care unit. RN's and EN's administer medication in the hospital unit. Staff attend medication administration training and staff have completed medication and insulin competencies. RNs have completed syringe driver training. There was one self-medicating resident in the rest home with a current competency and assessment completed. Medications were stored securely in the resident's room. There are current standing orders. Medication administration is observed to be compliant during the audit.</p> <p>There are weekly controlled drugs checks sighted in the controlled drug registers. This is an improvement since the previous audit. The pharmacy undertakes a six monthly controlled drug stocktake. The RNs complete a stocktake at the bottom of each page in the controlled drug register. Medications to be returned to the pharmacy are stored securely until collected by the pharmacy. Medication fridge's are monitored weekly (records sighted). Oxygen, suction and emergency trolley in the hospital unit is checked and signed off (as sighted). There are no gaps identified on the 16 medication signing sheets reviewed (six hospital, two RH, two rest home in serviced apartments and six dementia care). As required medications have the time of administration on the signing sheet. Controlled drugs are signed by two persons. Dietary supplements, antibiotics and short course have signing sheets. Alert labels include "look for second pack", "short course medications" and "controlled drugs".</p> <p>Medication charts sampled record prescribed medications by residents' general practitioner, including as required medication and the indications for use. All medication charts have photo identification (dated) and allergies/adverse reactions documented.</p> <p>D16.5.e.i 2; Sixteen medication charts reviewed identified three monthly medication reviews signed by the attending GP. This is an improvement since the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a company hotel services manager. The service employs a qualified chef who works as the head chef Monday to Friday, and a chef who works the weekends. The chef is supported by a cook assistant and a morning and afternoon kitchen hand each day. There is a four weekly seasonal menu that has been designed and reviewed by a dietitian at organisational level. The chef receives a resident dietary profile for all new admissions and is notified of dietary changes following the six</p>

		<p>monthly reviews and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are written up on the kitchen whiteboard. Normal, mouli, vegetarian, diabetic diets and gluten free diets are provided. Food is delivered in hot boxes to the kitchenettes and dining areas in each area and served from Bain Marie. Caregivers and activities staff serves the meals and have a resident like/dislike list in each dining area. The cook plates and labels special diets. Nutritious snacks such as desserts, yoghurt, custard, biscuits and sandwiches are available over 24 hours for residents in the dementia unit. Staff are observed sitting with the resident when assisting them with meals.</p> <p>The service has a large workable kitchen with a separate dishwashing area, baking, cooking and storage areas, a walk-in chiller, freezers and freezers, walk-in pantry, two combi ovens and an electric oven. All foods are date labelled in the freezers and fridges. Dry goods in the pantry are sealed and date labelled. There is a three monthly clean of the large dry goods bins. Fridge and freezer temperatures are recorded daily and there is evidence of corrective action taken where temperatures are outside of the accepted range. Facility food fridges are monitored weekly. Hot food temperatures are recorded daily. Room temperatures are monitored. There is a cleaning schedule in place (sighted) which is signed off as duties are completed. Staff are observed wearing aprons, hats and gloves.</p> <p>The kitchen equipment is on a planned maintenance schedule. The preferred supplier provides chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. Chemicals are stored safely in the kitchen.</p> <p>There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal</p> <p>Feedback on the service is received from resident and staff meetings, surveys and audits.</p> <p>D19.2 Staff have been trained in safe food handling.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Residents interviewed report their needs are being appropriately met. Relatives interviewed state their needs are being appropriately met and they are kept informed of any changes to health and interventions required. This is evidenced in the progress notes with a "relative contact" stamp.</p> <p>D18.3 and 4 Dressing supplies are available and treatment rooms are adequately</p>

		<p>stocked for use. Wound assessment and wound treatment and evaluation plans are in place for five of eight residents with wounds (link 1.3.8). Short term care plans are in place for skin tears (1.3.8.2). There is access to external wound specialists as required. Continence products are available and resident files include a urinary and bowel continence assessment. Specialist continence advice is available as needed and this could be described by the three registered nurses 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, and the setting of the service.</p>	<p>PA Low</p>	<p>There are three activity coordinators at Ryman Bob Owens who provide a separate activity programme for the rest home, hospital, dementia care unit and serviced apartments. One of the activity staff is a psychopaedic nurse, one a psychiatric nurse and the other an enrolled nurse undertaking the diversional training (DT). The staff cover seven days a week and meets fortnightly to plan and co-ordinate activities. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The Ryman Engage programme is being established. There is a comprehensive programme that meets the needs of all consumers. Rest home and hospital residents mix and mingle as desired. One on one time is spent with residents who choose not to participate or who choose not to join in group activities.</p> <p>Residents are encouraged to maintain links with the community and there is contact with groups such as pre-school groups, school groups, visits by special needs children, concerts, community hymn singing, RSA, library, music and dancing. Church services are held weekly. There are regular outings and scenic drives for residents in all units. The service has two vans. A mobility taxi is hired to ensure hospital level residents (wheelchair bound) have an opportunity to go out. Residents in the dementia care unit are taken for supervised outdoor walks and scenic drives. Activities in the dementia unit are individualised and based on sensory activities and normal daily activities. Resident meetings and surveys provide feedback on the activities programme. Residents and relatives interviewed discussed enjoyment in the programme and the diversity offered to all residents. Activities plans reflect resident's current needs for five of eight files sampled.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated in six of eight files sampled. Evaluation of wounds is inconsistent.</p> <p>D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.</p>

		<p>The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against goals. Short term care plans are used for short term needs. Family are invited to attend the multidisciplinary review meetings (correspondence noted in files sighted). Resident medications and medical status are reviewed at least three monthly by the general practitioners.</p> <p>D 16.3c: Eight of eight initial care plans had been evaluated by the RN within three weeks of admission.</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 service displays a current building warrant of fitness which expires on 12 August 2015. The service is divided into three floors with rest home, hospital and the special care unit on different levels. There are serviced apartments on all levels. There is a central reception area, a large communal lounge and dining room for village residents. Each unit in the care centre has a lounge and dining area. The maintenance team address any maintenance requests or call in contractors as required. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and electrical testing – all of which are current (conducted September 2014). There is a gardening team responsible for the grounds and gardens. The maintenance team attend the facility meetings which include maintenance and preventative maintenance. Hot water temperatures in resident areas are monitored monthly and stable between 38-44 degrees Celsius. Internal audits for water temperatures have been conducted.</p> <p>The facility is carpeted with vinyl surfaces in bathrooms/toilets and kitchen areas. Resident rooms have fitted carpet. The corridors are carpeted. There is adequate space around the facility for storage of mobility equipment.</p> <p>There is an outside area with shade and seating that is observed to have well maintained paths. The special care unit has an open courtyard terrace with seating and raised garden beds and boxes.</p> <p>E3.4d. the lounge area is designed so that space and seating arrangements provide for individual and group activities.</p> <p>ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, standing and lifting hoists, mobility aids, transferring equipment, sensor mats, electric beds, ultra-low beds, hospital level specialised lazy boy chairs</p>

		<p>on wheels and weighing scales</p> <p>E3.3e: There are quiet, low stimulus areas that provide privacy when required</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>	FA	<p>The surveillance policy states the planned surveillance programme is organised and promoted via the Ryman accreditation programme calendar. Effective monitoring is the responsibility of the infection prevention coordinator who is a RN in the hospital unit. An individual infection report form is completed for each infection. Data is logged, which gives a monthly infection summary. All meetings held at Bob Owens include discussion on infection prevention control (IPC). The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation. There have been two outbreaks of infection within the facility since the previous audit. Improvements identified during the first outbreak included staff being permanently allocated to work in specific areas and the setting up of outbreak kits with sufficient supplies available. These improvements minimised the spread of infection during the second outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Low	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. There are five residents with restraints (four with bedrails and one with bedrail and lap belt). There are no enablers in use. The restraint co-ordinator (hospital RN) maintains a monthly restraint register. Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval process. Restraint use is included in the orientation for clinical staff. Challenging behaviour and alternative strategies to restraint use education has been provided (link 1.2.7.5). There are improvements required around restraint evaluations and restraint monitoring.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Staff training records are maintained. Training needs for staff are identified and discussed during the annual performance appraisal process. The education programme covers mandatory training and clinical education sessions.</p> <p>Seventeen of 19 caregivers employed in the dementia care unit have completed the dementia unit standards.</p>	<p>1) Not all staff have attended mandatory training in the last year. A recent quality improvement to encourage attendance is holding sessions in each unit and at the conclusion of staff meetings.</p> <p>2) Two out of 19 caregivers employed in the dementia care unit for over six months have not commenced the dementia unit standards.</p>	<p>1) Ensure all staff attend mandatory training.</p> <p>2) Ensure caregivers working in the dementia unit have completed the required education.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit)</p>	PA Low	<p>The service has a contracted GP to provide medical care and complete admissions within 48 hours. Timely admissions and medical notes were documented in seven of eight files reviewed. The previous finding at</p>	<p>One of eight files (rest home in serviced apartment) did not contain GP admission notes.</p>	<p>Ensure all residents are admitted by the GP within 48 hours and medical notes are retained in the resident file.</p>

is provided within time frames that safely meet the needs of the consumer.		certification remains.		90 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>	PA Low	<p>Weigh chair scales (calibrated) were used to weigh residents monthly or more frequently for the monitoring of weight loss/gain. Weight loss short term care plans were in place for residents with identified weight loss. Nutritional needs screening tools were in use. GP and dietitian referrals and allied health notes are evident in the five resident files sampled with identified weight loss.</p> <p>Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment for at risk residents. Accident /incidents are investigated for cause and corrective actions including a physiotherapist review, the use of sensor mats, hip protectors, clutter free rooms and mobility aids made available.</p> <p>There is a head injury protocol that includes neurological observations.</p> <p>Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour nursing care plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best</p>	<p>(i) Five of eight resident files sampled (two hospital, two rest home and one dementia care unit) have not had weights completed as per GP/dietitian instructions. (ii). One hospital resident with high falls risk and frequent falls did not have a review of the falls risk assessment post falls. (iii). Neurological observations were not fully completed for one resident (rest home in serviced apartment) post fall with head injury. (iv) There are no documented interventions for one dementia care resident with altered behaviours identified in the progress notes.</p>	<p>i) Ensure allied health instructions for weight loss is followed. ii) Review falls risk assessments for high risk residents post falls. iii) Ensure neurological observations are completed post falls with head injury. iv) Ensure interventions are documented for residents with altered behaviours.</p> <p>90 days</p>

		used to manage behaviours. Behaviour monitoring charts are in place for all dementia care unit residents to monitor behaviours and the effects of commencement or reduction of psychotropic medications. This remains a finding from the previous audit.		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	The resident is assessed with family involvement if applicable and likes, dislikes, hobbies, and past interests are discussed. An activity plan is developed in six of eight resident files sampled. The resident is encouraged to join in activities that are appropriate and meaningful. Resident files include an activities assessment, 'your life experiences' and next of kin input into activities plan.	<p>i) One resident activity plan was not reviewed to reflect the resident's current recreational status due to changes in health condition. ii) Two residents (one rest home and one dementia care unit) activity plans have not been completed. iii) Activity plans are not reviewed at the same time as care plans.</p>	<p>i) Ensure activity plans are reviewed to reflect changes in recreational and health status. ii) Ensure activity plans are completed for all residents. iii) Ensure activity plans are reviewed at the same time as the care plans.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	D16.4a Six of eight long term care plans had been evaluated six monthly or more frequently when clinically indicated. Short term care plans are in use for short term needs.	<p>(i) Two resident long term care plans (one rest home and one hospital) have not been evaluated six monthly ii) short term care plans for two skin tears have not been evaluated and signed out. iii) Evaluations of wounds are inconsistent. One of four pressure areas did not have dressings completed as per the frequency on the assessment.</p>	<p>i) Ensure long term care plans are evaluated at least six monthly. ii) Ensure short term care plans are evaluated and signed off. iii) Ensure wounds are evaluated and dressings changed as per the documented frequency.</p> <p>90 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	Written evaluations are evident in resident files sampled.	Two long term care plans (dementia care unit) do not reflect changes identified in the written evaluation.	<p>Ensure the care plan evaluation reflects identified changes.</p> <p>90 days</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>	PA Low	The use of restraint is documented in the restraint care plan. Risks and care required during the restraint period is identified in the restraint care plan. Three resident files were sampled. Consents are present in all files. Restraint assessments have been completed prior to the application of restraint. There are restraint monitoring guidelines in place.	1) Restraint assessments in two out of three files sampled had not been reviewed three monthly. 2) Monitoring forms for all five residents on restraint are incomplete.	<p>1) Ensure the restraint assessment is reviewed at least three monthly as per protocol. 2) Ensure restraint monitoring documentation is completed.</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.