

Bob Scott Retirement Village Limited - Bob Scott

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 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 Scott Retirement Village Limited
Premises audited:	Bob Scott
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: 25 May 2017 End date: 26 May 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	71

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

Bob Scott is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital and dementia level of care for up to 115 residents in the care centre and rest home level of care for up to 30 residents in serviced apartments. On the day of audit there were 70 residents including three rest home residents in the serviced apartments.

The service is managed by a village manager and clinical manager/registered nurse. Both have been recently appointed and are supported by a regional manager with many years' experience in aged care. The residents and relatives interviewed spoke positively about the care and support provided.

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 a general practitioner.

An area for improvement was identified around meetings, InterRAI assessments, care plans and an aspect of medication.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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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 documented 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. A comprehensive 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

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.		Some standards applicable to this service partially attained and of low risk.
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provides an activities programme which is varied and interesting for each resident group. The engage programme meets the abilities and recreational needs of the group of residents including outings.

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

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours.

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. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites. There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. There is a person on duty at all times, with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

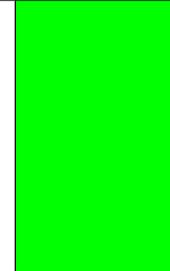
Restraint minimisation and safe practice

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 was one resident with a restraint and no residents with an enabler at the time of the audit. Staff receive training around restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. There have been no outbreaks in the care centre.

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	46	0	4	0	0	0
Criteria	0	97	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner (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 (one village manager, one assistant to the manager, one clinical manager, one regional manager) and twelve care staff (three registered nurses (RNs), six caregivers (two rest home, two hospital and two dementia care) and three activities 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 choices and give informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in nine resident files (three hospital including one respite resident and one resident under chronic medical illness, four rest home including one resident in the serviced apartments and two dementia care) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with a family member stated that the service actively involves them in decisions that affect their relative's</p>

consent.		lives. Eight resident files of long-term residents have signed admission agreements and the respite care resident has signed a short-term agreement.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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 include information on the resident's family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were 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.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy is being implemented at Bob Scott. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The facility has an up-to-date complaint register. Concerns and complaints are discussed at relevant meetings. One complaint was made in 2016 and two complaints received in 2017 year to date. Follow-up letters, investigation and outcome were documented. Corrective actions have been implemented and any changes required were made as a result of the complaint. Interviews with residents and relatives confirmed they were provided with information on the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	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 (two rest home, two hospital and one dementia care) and seven residents (five rest home and two hospital) 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 and clinical manger 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. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors 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.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	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. Links are established with local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. There were two residents who identified as Māori at the time of the audit. One Māori resident file reviewed confirmed that Māori cultural values and beliefs are being met and are addressed in the care plan.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	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 consider their values and beliefs.
Standard 1.1.7: Discrimination	FA	Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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>FA</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. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. 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 practice, based on the evidence provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fourteen incident forms reviewed for April and May 2017 identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters is available. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Relatives interviewed stated that they are informed when their family members health status changes. The information pack is available in large print and this can be read to residents. The information pack and admission agreement included payment for items not included in the services. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. A specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility.</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</p>	<p>FA</p>	<p>Bob Scott is a Ryman healthcare retirement village providing rest home, hospital and dementia level care for up to 115 residents. The facility is across five levels. This includes 34 rest home level beds on level four, 41 dual-purpose beds (hospital and rest home) on level three and 40 dementia level beds (two 20 bed units) on level two. The service has 30 serviced apartments certified as able to provide rest home level care. Level one and level five are serviced apartments only. There are also serviced apartments across all floors. There were three residents receiving rest home care in the serviced apartments on level three at the time of</p>

<p>of consumers.</p>		<p>the audit. Occupancy during the audit was 70 residents in total, 39 rest home level residents (including two in the dual-purpose beds and three in the serviced apartments), 15 hospital level residents (including one resident on respite care and one under 65 years with a chronic illness under the ARCC). One dementia unit was open with 16 of 20 residents.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation-wide objectives are translated at each Ryman service by way of the teamRyman programme that includes a schedule across the year. The village quality objectives and quality initiatives for 2017 have been set with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2017 objectives.</p> <p>The village manager at Bob Scott has been in the role since March 2017 and has an extensive background in facility management in aged care. She is supported by an assistant to the manager, who carries out administrative functions and a clinical manager who oversees clinical care and support for the village manager. The clinical manager been in the position for two months. The managers are supported by a unit coordinator in each area. The management team is also supported by the Ryman management team including the regional manager. The regional manager was present on the days of the audit. The village manager and clinical manager have both completed specific manager orientation with Ryman.</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 (RN) will fulfil the manager's role during a temporary absence of the village manager with support from the regional manager and Ryman management team.</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</p>	<p>PA Low</p>	<p>Bob Scott has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team (village manager, assistant to the manager and clinical manager) and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities. Family meetings are held six monthly and residents' meetings are held every two months. Meeting minutes are available; however, the meetings have not occurred as</p>

<p>reflects continuous quality improvement principles.</p>		<p>scheduled. Annual resident and relative surveys are completed. The first resident satisfaction survey was completed in February 2017 with an overall satisfaction rate of 92.9%. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</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. These are communicated to staff, as evidenced in staff meeting minutes and sighted on the staff noticeboards.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems, policies and procedures are developed, implemented and regularly reviewed. The facility has implemented processes to collect, analyse and evaluate data, which is 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>Falls prevention strategies are in place that include; hi/lo beds, ongoing falls assessment and exercises by the physiotherapist, sensor mats, fall prevention pamphlets and appropriate footwear.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative (café assistant) is appointed who is due to complete the health and safety training in June 2017. 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 and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. 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 indicates that there is resolution of issues identified.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of fourteen incident/accident forms from across all areas of the service, identified that all are fully completed and include follow-up by a RN. The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur. The village manager and regional manager could identify situations that would be reported to statutory authorities</p>

family/whānau of choice in an open manner.		including (but not limited to) infectious diseases, serious accidents and unexpected death.
<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>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Ten staff files reviewed (one clinical manager, one hospital unit coordinator, one rest home unit coordinator, two RNs, three caregivers, one kitchen manager and one activities coordinator) provided evidence of signed contracts, job descriptions relevant to the role the staff member is in, induction, application form and reference checks. A register of RN and enrolled nurse (EN) practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Six caregivers work in the dementia unit. Five of the six caregivers have completed their dementia qualification. The caregiver that has not completed has commenced work within the last 12 months and is working towards completing their qualification.</p> <p>Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Health practitioners and competencies policy outlines the requirements for validating professional competencies. Copies of practising certificates are held by the village manager. There are currently ten RNs working at Bob Scott. Six of ten RNs are InterRAI trained, including the clinical manager.</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>	FA	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The village manager and clinical manager, work fulltime Monday to Friday and are on call 24/7. Each service unit in the care centre has a RN/EN unit coordinator. There is at least one RN and first aid trained member of staff on every shift. Interviews with caregivers informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated that overall there was sufficient staff to meet resident needs.</p> <p>Staffing at Bob Scott is as follows; in the rest home unit on level four (34 rest home and four rest home residents in the serviced apartments) on the morning shift: there is one RN and four caregivers, afternoon shift: three caregivers, night shift: two caregivers, the RNs in the hospital oversee the rest home unit in the afternoon and night shifts. In the hospital unit on level three (15 hospital and two rest home residents) on the morning shift: there are two RNs and nine caregivers, afternoon shift: two RNs and seven caregivers,</p>

		<p>night shift: one RN and three caregivers.</p> <p>In the dementia unit on level two, only one unit is open (16 residents) on the morning shift: there is one RN and two caregivers, afternoon shift: three caregivers (including one lounge carer), night shift: two caregivers, the RNs in the hospital oversee the dementia unit in the afternoon and night shifts.</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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term and short-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has 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.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and</p>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with ministry of health medication requirements. Medication reconciliation is completed by the RN on delivery of medication and any errors fed back to pharmacy. Registered nurses, enrolled nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed could describe their role in regard to medicine</p>

<p>timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>administration. Education around safe medication administration has been provided. Medications were stored safely in all the units. Medication fridges were monitored daily. Expiry dates of medications are checked weekly. All eye drops were dated on opening.</p> <p>Standing orders are not used. There was one rest home resident in the serviced apartment that had been assessed as competent to self-administer by the RN and GP.</p> <p>Eighteen medication charts (eight rest home including two rest home in the serviced apartments, six hospital including one respite (paper based medication chart) and four dementia care) medication charts were reviewed on the electronic medication system. All medication charts reviewed have 'as needed' medications prescribed with an indication for use. The effectiveness of 'as required' medications are entered into the electronic medication system. Oxygen had not been prescribed for one resident in the serviced apartments.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food and baking is prepared and cooked on-site. The qualified chef is supported by a cook and kitchen assistants. All staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with company chef and the dietitian at organisational level. Menu sheets are completed for individual residents for the week ahead. The menu offers two choices including a vegetarian dish. Meals are plated in the main kitchen and delivered to the units in hot boxes.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft, diabetic desserts and gluten free are provided.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received through direct feedback, resident meetings, surveys and audits.</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</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Risk assessments have been completed on admission and reviewed six monthly as part of the evaluation process. The outcomes of InterRAI assessments and risk assessments (link 1.3.3.3) that were triggered were reflected in the care plans reviewed (link 1.3.5.2). Additional assessments such as behavioural, wound and restraints were completed according to need. Assessed needs and supports required were described in care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Care plans reviewed demonstrated service integration and input from allied health. Resident care plans were resident centred and support needs and interventions were documented to reflect the resident goals, however not all care plans had been updated to reflect the resident's current health status. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Residents (if appropriate) and family stated they were involved in the care planning and review process. Behaviour management including triggers, interventions and successful de-escalation techniques was included in the long-term care plan in two of the two dementia care resident files.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	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 registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Short-term care plans are developed for infections. Wound assessments, treatment and evaluations were in place for skin tears, two chronic ulcers and 10 facility pressure injuries. A quality improvement plan is in place to reduce pressure injuries. A RN/wound champion has been appointed. There is access to a wound nurse at the DHB. Adequate dressing supplies were sighted in the treatment rooms. Contenance products are available and resident files include a three-day 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. Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.

<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>FA</p>	<p>There is a team of activity coordinators to coordinate and implement the Engage programme. The hospital activity coordinator is a qualified caregiver and is supported by a weekend activity person to provide a seven-day week programme. The rest home coordinator is progressing through the diversional therapy (DT) course and provides a Monday to Friday programme. The dementia care unit activity person is a qualified DT and has completed dementia unit standards. All activities persons have a current first aid certificate.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group such as Triple A exercises. Rest home residents in the serviced apartments attend either the serviced apartment programme or rest home programme. There are adequate resources available. Residents receive programmes in their rooms. Daily contact is made with residents who choose not to be involved in the activity programme. The service has goals for a men's group to commence. School children visit the residents' fortnightly. Special events and theme days are celebrated. All residents can go on outings and a taxi van is hired for hospital residents in wheelchairs. Rest home residents enjoy inter-home visits. There are weekly integrated church services. Residents in the dementia care unit attend facility activities as appropriate and under supervision and residents were observed going for supervised walks into the facility grounds and gardens. Entertainers visits each unit on a regular basis.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident meetings and satisfaction surveys.</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>Six of nine care plans had been evaluated by registered nurses six monthly. Two residents had not been at the service six months (one rest home and one dementia care) and one resident was for respite care. Written evaluations describe the resident's progress against the residents identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. 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 1.3.9: Referral To Other Health And Disability</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</p>

<p>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>resident files. There was evidence of where a resident's condition had changed and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice and contracted allied services.</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 were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. Staff have attended chemical safety training.</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 9 March 2018. The facility employs a fulltime maintenance person who has been involved in the construction of the building. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule which has been signed as completed (sighted). Essential contractors are available 24-hours. Electrical testing and annual calibration is not yet due as all equipment was purchased new, less than one year ago. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>The dementia units on the second floor each have an outdoor balcony deck with raised gardens and two entry/exit doors into the facility providing a walking pathway.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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 bedrooms in the rest home, hospital and dementia units are single occupancy and have full ensuites. Fittings and fixtures are made of easy clean surfaces that meet infection control practice. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. Residents are encouraged to personalise their bedrooms.</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>The dementia care unit, rest home and hospital units have a main lounge and family lounge. The large main lounges have seating placed to allow for individual or group activities. The dining room in each unit is spacious. The communal areas are easily accessible for residents using mobility aids or staff assistance.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry. The chemical provider monitors the use of chemicals and laundry processes.</p>

<p>appropriate to the setting in which the service is being provided.</p>		<p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The service provides a clothes labelling service for residents.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Orientation includes emergency preparedness. There are staff employed across the facility 24/7 with a current first aid certificate. Battery operated emergency lighting is in place which runs for at least two hours if not more. The facility has an on-site diesel generator to run essential services. There is a civil defence kit located on each level. Supplies of stored drinkable water is stored in large holding tanks. There is sufficient water stored to ensure three litres per day for three days per resident. The facility has an approved fire evacuation plan and fire drills take place six-monthly. The last fire evacuation drill occurred on 9 December 2016. Smoke alarms, sprinkler system and exit signs are in place. There are alternative cooking facilities available with three gas barbeques and gas hobs in the kitchen. Gas heaters are available if required. The call bell system is evident in residents' rooms, lounge areas and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advise that they conduct security checks at night, in addition to an external contractor. A security camera is installed at the entrance.</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>	<p>FA</p>	<p>General living areas and resident rooms are appropriately ventilated and heated with underfloor heating. All rooms have external windows with plenty of natural sunlight.</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</p>	<p>FA</p>	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control committee is combined with the health and safety committee, which meets bi-monthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is sent out annually from head office and directed via the quality programme. The programme is reviewed annually at head office. A six-month analysis is completed and reported to the governing body. Infection control objectives for 2017 reflect the outcomes of surveillance and quality data. The clinical manager is the infection control officer with a job description outlining the responsibilities for</p>

<p>shall be appropriate to the size and scope of the service.</p>		<p>infection prevention and control at the facility.</p> <p>Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine. There are adequate hand sanitisers and infection control signage throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control committee (combined with the health and safety committee), is made up of a cross section of staff from areas of the service. The infection control officer has completed infection control and prevention training on-line training. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, local laboratory, infection control consultants and expertise from within the organisation.</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 were comprehensive infection prevention and control policies that were 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 developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate. All staff can access the electronic policies.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	<p>FA</p>	<p>The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions and training is provided both at orientation and as part of the annual training schedule. Hand hygiene competencies are completed. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>

consumers.		
<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 described the purpose and methodology for the surveillance of infections. Definitions of infections in place 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 and control officers complete a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks in the care facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there was one resident with a restraint (chair brief) and no residents using an enabler. Staff training has been provided around restraint minimisation.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The file for the one hospital level resident using restraint was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the resident's file reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in the residents' file reviewed where restraint was in use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</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)
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	Discussions with the management team (village manager, assistant to the manager and clinical manager) and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities. There had been no formal documented meetings from May - September 2016. Three out of nine full facility meetings, four out of nine management, four out of nine RN/EN clinical meetings and six out of nine teamRyman meetings from September 2016 to May 2017 had not been completed as per annual meeting calendar schedule.	Not all facility meetings have been completed as per annual meeting calendar schedule. Required actions and resolutions identified in meetings have not been consistently documented, followed up or completed.	Ensure that all facility meetings are completed as per annual meeting calendar schedule and any required actions are followed up or

				completed. 90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>Sixteen of seventeen medication charts on the electronic medication system evidenced the medication had been administered as prescribed. Medication charts met the prescribing requirements. The GP had reviewed the medication charts three monthly. Oxygen had not been prescribed for one rest home resident in a serviced apartment.</p>	<p>One rest home resident in the serviced apartments was on continuous oxygen long term via a concentrator. The oxygen had not been charted on the medication chart.</p>	<p>Ensure oxygen therapy is prescribed on the medication chart.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Eight long-term resident files were reviewed to determine timeframes around the first InterRAI assessment. The file number was extended to nine long-term resident files. Initial assessments, long-term care plans and the first InterRAI assessment had been completed within the required timeframes in six of nine long-term resident files reviewed.</p>	<p>Three long-term resident files reviewed (one hospital and two rest home) did not have an InterRAI assessment completed within 21 days of admission.</p>	<p>Ensure all new admissions have an InterRAI assessment completed within 21 days of admission.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p>	PA Low	<p>Three of eight long-term care plans reviewed reflected the resident current needs and</p>	<p>(1)Five long-term care plans did not reflect the resident's current needs and supports. Three</p>	<p>Ensure all long-term</p>

<p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>supports. One respite care resident had a nursing assessment and care plan in place that met the resident's needs.</p>	<p>hospital residents' care plans did not document the following needs for residents: (i) Pressure injury interventions did not reflect the assessed very high risk of pressure injury. Ankle oedema and use of compression stockings as per GP notes was not included in the long-term care plan. (ii) There was no pain assessment or pain management plan for a resident with a new pain requiring GP visits and analgesia. (iii) There were no documented interventions for a resident with weight loss.</p> <p>(2)Two rest home residents care plans did not document the following needs for residents: (i) The pain management plan was not current (link rest home tracer). (ii) A resident's known pain and pain management was not documented in the long-term care plan. For the same resident, the resident's recommendation for hip protectors had not been followed up.</p>	<p>care plans reflect the outcomes of assessments and reflect the resident's current needs and supports.</p> <p>60 days</p>
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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, 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.