Charles Upham Retirment Village Limited - Charles Upham Retirement Village

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:	Charles Upham Retirement Village Limited
Premises audited:	Charles Upham Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 28 August 2017 End date: 29 August 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 83

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 Charles Upham opened in November 2016 and provides rest home, hospital and dementia level care for up to 120 residents in the care centre. There are also 30 serviced apartments certified for rest home level of care. On the day of the audit there were 83 residents including four in the serviced apartments.

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

The service is managed by a non-clinical village manager with experience managing health professionals in a health and safety workplace environment. She has been in the role for 18 months (since prior to the opening of the care centre). She is supported by a clinical manager who has also been in the role for 18 months and has experience in maternity, general practice and in the DHB. The residents and relatives interviewed all spoke positively about the care and support provided.

This certification audit identified areas for improvement around timeliness of documentation, progress notes, wound documentation and updating care plans when needs change.

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.

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives 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. There is an established system for the management of complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvement are identified. The risk management programme includes managing adverse events and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

The service has a comprehensive admission pack that includes information on all the levels of care and services provided. Registered nurses are responsible for all stages in the provision of care including interRAI assessments, risk assessments, development of care plans and evaluations. Resident files demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review and were informed of any changes in resident health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme which is varied and interesting. The programme meets the abilities and recreational needs of the different groups of residents. Residents are encouraged to maintain links with community groups.

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. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in all units.

Safe and appropriate environment

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

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are 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 is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. 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.

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.

The service has appropriate procedures for the safe assessment and review of restraint and enabler use. During the audit, no residents were using restraints and no residents were using an enabler. 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. The infection prevention and control programme includes policies and procedures to guide staff. Surveillance data identifies trends and areas for improvement. Organisational benchmarking occurs.

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	43	0	2	0	0	0
Criteria	0	90	0	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	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. Three managers (one village manager, one clinical manager and one regional manager), eleven caregivers (one from the serviced apartments, three from the special care (dementia) unit, three from the hospital, three from the rest home and one who works in both the rest home and the special care unit), eight registered nurses (RNs), (one dementia, six hospital and one who works in both the dementia unit and the rest home) and six activities staff (two from the hospital, two from the dementia unit, one from the rest home and one that works throughout the facility) 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.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice	FA	Informed consent processes are discussed with residents and families on admission and are included in the admission agreement. Specific consents were viewed for wound photographs and influenza vaccines. Written consents were sighed as part of the 10 resident file reviews (three hospital, five rest home including two residents in a serviced apartment one respite and one permanent, and two dementia care). Advance directives and/or resuscitation status are signed for separately by the competent resident. Copies of

are provided with the information they need to make informed choices and give informed consent.		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. Family members interviewed stated that the service actively involves them in decisions that affect their relative's lives.
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 service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. There have been 13 complaints received since the service opened. Nine of these were reviewed and all were documented as resolved. Corrective actions have been implemented and any changes required were made because of the complaint.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed	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. Eight relatives (two rest home, two hospital and four dementia) and eleven residents (six rest home and five hospital) stated they were provided with information on admission which included the Code. Large print posters of the Code and advocacy information are displayed

of their rights.		throughout the facility. The village manager reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope.
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. Staff attend education and training on abuse and neglect.
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 no residents that identified as Māori at the time of the audit.
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,	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.

and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	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 mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 number of core clinical practices also have education packages for staff, which are based on their policies. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch (formerly known as head office) 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 Ryman programme (previously known as Ryman Accreditation Programme RAP). 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. Charles Upham provided examples of good practice. These included two current projects. The first is the service working in collaboration with residents, the contracted medical centre and the DHB to ensure all residents have either an advance care plan or a medical care guidance plan. At the time of the audit all residents in the dementia unit had an activated EPOA that was also held by the medical centre and the DHB, and the family if they wish and either an advance care plan or a medical care guidance plan, also held by the DHB and medical centre. These are also published on the DHBs secure website, Health One, an integrated electronic portal where all primary and secondary care providers can access the information. The second is working with the contracted medical centre to limit admissions to the CDHB emergency department by using the 24-hour call system. The medical centre can be accessed after-hours and in weekends either by ambulance or by visiting the clinic in Amberley. The service continues to collect data and evidence to support this model and early data shows below average emergency department admissions.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Regular contact is maintained with family including if an incident or care/health issue arises. Evidence of families being kept informed is documented on the myRyman electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Sixteen incident/accident forms and corresponding residents' files were reviewed and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed for residents who are unable to speak or understand English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Charles Upham is a Ryman retirement village located in Rangiora that opened in November 2016. The service provides care for up to 120 residents at hospital, rest home and dementia level care in the care centre and up to 30 residents at rest home level care in serviced apartments. On the day of audit there were 83 residents in total, including two rest home level of care and two rest home respite care residents in the serviced apartments. All rooms in the rest home (level one) and the hospital (level two) are dual-purpose. There were 34 (of 40) residents on level one – 33 rest home level including two residents on respite care and one hospital level resident. On level two there were 24 (of 40) residents); two rest home level residents and 22 hospital level residents including two on respite care. The ground floor also has two secure 20-bed dementia units. There were 19 residents including two on respite care in one unit and two residents in the other. At the time of the audit the two units, which adjoin and have connecting doors were operating as one unit to provide company for the two residents in the second unit. The DHB is aware of this arrangement. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are translated at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific village objectives 2017 and progress towards objectives is updated as part of the TeamRyman schedule. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and dementia care. The village manager at Charles Upham is non-clinical and has been in the role since June 2016. She is supported by a clinical manager/registered nurse (RN) who has been in the role for the same length of time. The clinical manager has worked in DHB environments, maternity care and general practice. She is supported

		by an experienced unit manager in each area (registered nurses in the rest home, hospital and dementia units and an enrolled nurse in the serviced apartments) and receives mentoring from head office and the clinical manager at another nearby Ryman facility, where she also completed part of her orientation. They are also supported by a regional manager and an assistant to the manager. The regional manager was present during the days of the audit. Ryman provide ongoing training for managers and clinical managers.
Standard 1.2.2: Service Management 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.	FA	The clinical manager is responsible during the temporary absence of the village manager, with support from the regional manager and Ryman management team.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Charles Upham has begun implementing the 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, clinical manager and regional 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 in the hospital and in the rest home. Meeting minutes are maintained. A resident survey has not yet been completed. 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. 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. Falls prevention strategies are in place that include, hi/lo beds, ongoing falls assessment, sensor

		mats, fall prevention pamphlets and appropriate footwear. Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative (senior caregiver) is appointed and they have completed the health and safety training. 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.
Standard 1.2.4: Adverse Event Reporting 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.	FA	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. However, required interventions are not always transferred to care plans (link 1.3.8.3). The clinical manager is involved in the adverse event process, with links to the applicable meetings (RN, full staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur. The village manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. A section 31 form was sighted for the reporting of an unstageable pressure injury.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Ten staff files reviewed (one clinical manager, one serviced apartments unit coordinator (enrolled nurse), three RNs, three caregivers, one activities coordinator (from the dementia unit) and one kitchen manager 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 EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration. An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. All staff who commenced at the time the service opened completed an orientation prior to the opening. 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. Not all required training has yet been provided in the in-service programme but these topics were all included in the orientation programme which each staff member has

		completed in the last year. Twelve caregivers work in the dementia unit. Three have completed their dementia qualification and a further six are nearing completion. No staff have worked at the service for a full year. The service supports staff to undertake aged care qualifications with many staff working toward these. Registered nurses are supported to maintain their professional competency. They also attend a monthly journal club which requires pre-reading and then discussion around a variety of relevant topics. 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. There are currently eleven RNs working at Charles Upham. Four of the eleven RNs are interRAI trained, one is nearing completion of training and one more is enrolled to attend training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The village manager and clinical manager, work full time 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. Caregivers reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are sufficient staff to meet resident needs. Staffing at Charles Upham is as follows: In the rest home unit on level one (33 rest home residents including two rest home residents in the serviced apartments and one hospital level resident (with similar needs to rest home level residents): AM shift: Unit coordinator (RN) 7.30am to 4.00pm every day, two caregivers 7.00am to 3.00pm, two caregivers 7.00am to 1.00pm. PM shift: two caregivers 3.00pm to 11.00pm, one caregiver 3.00pm to 9.00pm, one caregiver 3.00pm to 8.30pm. Night shift: two caregivers. In the hospital on level three (22 hospital level residents and two rest home level residents): Unit coordinator (RN) from Sunday to Thursday). AM shift: Two registered nurses, three caregivers 7.00am to 3.00pm and three caregivers 7.00am to 1.00pm. PM shift: one registered nurse, two caregivers 3.00pm to 11.00pm, three caregivers 3.00pm to 9.30pm. Night shift: One registered nurse and two caregivers. Special care unit (dementia unit): One 20 bed unit with 19 residents and one 20 bed unit with 2 residents – currently the two units are operating as one unit. AM shift: Unit coordinator (RN) for five days, registered nurse and a senior caregiver on the other two days, two caregivers 7.00am to 3.00pm, one caregiver to 1.00pm. PM shift: two caregivers 3.00pm to 11.00pm, one caregiver 3.00pm to 9.00pm. Night shift: one caregiver. Serviced apartments: Three rest home level residents on one floor (including one married couple) and one rest home resident on the floor above. AM shift: Unit coordinator (EN) three days 8.30am to 4.30pm, senior

		caregiver on this shift the other two days, one caregiver 7.00am to 1.00pm. PM shift: one caregiver 4.00pm to 9.00pm. The clinical manager supports the unit coordinator with checking of assessments and care plans. When there are no staff rostered in the serviced apartments the staff in the rest home check on the residents and answer bells as confirmed by the rest home level resident interviewed in a serviced apartment and rest home staff. The rest home is on the same floor as three of the four rest home level residents in the serviced apartments.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were appropriate to the service type. The service had introduced the myRyman electronic resident database two weeks prior to the audit. The database can be accessed from a surface device in each resident's room where staff can document interventions in real time as cares are completed. Each resident's family can also access that individual residents myRyman file. Specific security measures are in place to protect the security of the information and a policy (currently in draft) has been developed to guide staff. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Entries in the database document the time the entry was made and who made the entry. Individual resident files demonstrate service integration.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. 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. Specific information around dementia care services is included in the information pack as applicable for dementia care admissions. The admission agreement reviewed aligns with the services contracts for long-term and short-term care.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation of monthly blister packs is completed by two RNs and any errors fed back to the pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency. Appropriate medications were signed by two medication competent staff, one of which was a RN. The service uses an electronic medication system. Care staff interviewed could describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all four units (rest home, serviced apartments, hospital and dementia care). Medication fridges were monitored weekly. All eye drops and creams in medication trolleys were dated on opening. There are two rest home level residents self-medicating inhalers. The inhalers are kept in a locked drawer in the resident rooms. RNs assess competency three-monthly. The competency is kept on file in the medication room. One resident in the serviced apartments was self-medicating. The EN checks daily to ensure medications have been taken. Competency is checked and signed by the GP. Medications are kept in the resident's room. Twenty medication charts were reviewed on the electronic medication system. All medications had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All food and baking is prepared and cooked on-site. The qualified head chef is supported by two chefs and four kitchen assistants. Staff have been trained in food safety and chemical safety. Project "delicious" was commenced at the time the facility opened. Menus are completed one week in advance and offer a choice of three main dishes for the midday meal and two choices for the evening meal including a vegetarian option. Resident dislikes are accommodated. Diabetic desserts and gluten free diets are accommodated. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Meals are plated in the kitchen and delivered in Scan boxes to the tables. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Nutritious snacks are available 24 hours in all units. The clinical manager informs the head chef of residents with weight loss and dietitian input to diets. Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. The chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.

		Residents provide feedback on the meals through resident meetings, survey and direct contact with the food services staff. Residents interviewed all spoke positively about the food provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to 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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	In the files reviewed, risk assessments had been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural, wound and restraints were completed according to need. The service has introduced the myRyman electronic resident individualised care programme. There are a number of assessments completed that assess resident needs holistically. The assessments generate interventions and narrative completed by the RNs that are transferred to the care plan. Assessments are completed when there is a change of health status or incident and as part of completing the six month care plan review. When assessments are due to be completed these are automatically scheduled in the RNs electronic daily calendar. All assessments and interventions updated are included in progress notes.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plan outlines objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs are met (link 1.3.6.1). The myRyman programme identified interventions that cover a comprehensive set of goals including medical needs. Key symbols on the residents electronic home page identity current needs such as (but not limited to); current infection, wound or fall. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Residents and relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident.
Standard 1.3.6: Service	PA Low	Residents interviewed reported their needs were being met. The family members interviewed stated their

Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		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. Care plans reflect the required health monitoring interventions for individual residents. The myRyman system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, for eg: resident turns, fluids given. Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved completes the short term care plan. Wound assessments, treatment and evaluations were in place for 14 residents with wounds (two dementia care, seven hospital and five rest home). These included 12 skin tears, one basal cell carcinoma and one chronic venous ulcer. Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Documentation was absent for the last six weeks of a now healed wound. Registered nurses interviewed could describe access to wound specialist nurses if required. The GP reviews wounds three monthly or earlier if there are signs of infection or non-healing. New wounds were recorded in the VCare and myRyman systems. Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.
Standard 1.3.7: Planned Activities 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.	FA	The team of activities staff (one with diversional therapy qualifications, one in diversional therapy training and one about to commence training and four activities coordinators) coordinate and implement the Engage activities programme across the rest home, hospital and dementia units. A separate programme operates for serviced apartment residents who can choose which programme they would prefer to attend. The programme is Monday to Friday in the rest home and serviced apartments and seven days a week in the hospital and dementia care unit. Activities staff attend on-site and organisational in-services relevant to their roles. Five of seven activities staff hold current first aid certificates. The designated bus driver holds a first aid certificate. The engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple A exercises, themed events and celebrations, baking, sensory activities including pets coming to visit, outings and drives. A facility van is available for outings for all residents. The hospital and rest home lounge areas have seating placed for large and smaller group activities. One-on-one activities occur as well as regular wheelchair walks out in the gardens. Daily contact is made with residents who choose not to be involved in the activity programme.

		Residents in the dementia care unit are taken for daily walks (observed) around the gardens and grounds as weather permits. Activities include music, entertainers visit weekly, pet therapy, van outings, visits to the library, triple A exercises twice a day, memory lane and group games. One-on-one sessions include hand and nail pampering and reading with residents. Community involvement includes entertainers, speakers, volunteers and visitors bringing in their pets weekly. There are opportunities for residents from all units to join together for larger celebrations, and to catch up with old friends if the resident has moved to the rest home from serviced apartments for example. 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 and relative meetings and satisfaction surveys. In the two dementia level files reviewed, all of the information around activities over the 24-hour period were documented throughout the care plans in various sections and there was evidence of offering cups of tea during the night to settle residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans had been evaluated by registered nurses for long-term residents who had been at the service six months and longer. Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care plan. Seven of nine files were not updated following completion of incident forms (link 1.3.6.1). The multidisciplinary review involves the RN, clinical manager, GP, care assistant, activities staff and other allied health professionals involved in the care of the resident. Record of the MDT review was evident in the resident files reviewed. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where 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 professionals.

service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policies. 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. There are locked cupboards within the sluice for storage of chemicals. There are secure cleaning cupboards on each floor. Safety datasheets and product use information was readily available. Relevant staff have attended chemical safety training. There is a key pad secured sluice in each wing on each floor.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires in January 2018. The building is three levels. The two dementia care units are on the ground floor, each with secure outdoor seating, shade and gardens. There are large landscaped secure gardens with safe walking pathways out of both units. The dementia units also include the Austco security system, which includes sensor lights in resident rooms; therefore, when a resident gets up at night, the lights illuminate depending on the location of the resident within the room. This is connected to the security system and can be timed to alarm if the resident doesn't go back to their bed. Doors are different colours to walls. The wall behind the toilet is darker to assist with making the toilet more noticeable. The units are designed with a service area consisting of a centrally located open nurse station that is accessed from both wings separately. These service areas are situated adjacent to the open plan dining and lounge areas of both wings. The first floor (middle floor) accommodates the rest home level unit. The rest home floor plan has she same T shaped corridors as the other units with a centralised nurses station, situated adjacent to the large lounge and dining areas. The second floor accommodates the hospital unit and is a mirror image of the level two dual-purpose unit. There are a number of landing strips and sensor mats available. There is a covered balcony off the lounge area. Serviced apartments all have a lounge area with kitchenette, a bedroom and bathroom. Call bells are situated in the lounge, bedroom and bathroom areas. Medications are stored in a locked cupboard on the ground floor beside the nurses' station (bureau). Residents in the serviced apartments have the option of joining other

		residents from the in the large communal areas. The service employs a full-time maintenance person who attends health and safety committee meetings. The maintenance person ensures daily maintenance requests are addressed. A 12-monthly planned maintenance schedule is maintained. Essential contractors are available 24-hours. Electrical testing is completed annually and is current. Annual calibration and functional checks of medical equipment is completed by an external contractor, last checked August 2017. Hot water temperatures in resident areas are monitored three-monthly, as part of the environmental audit. Temperature recordings reviewed were maintained below 43-45 degrees Celsius. All residents have safe access to outdoor gardens and courtyards. Seating and shade is provided.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All bedrooms are single occupancy and have full ensuites with disability showers, and underfloor heating. There are communal toilets located closely to the communal areas on all floors. Toilets have privacy locks. In the dementia unit, communal toilets are set apart by coloured doors and signs. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility and transferring aids such as hoists. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment,	FA	Charles Upham has the special care (dementia unit) on the ground floor, rest home on the first floor and two interlinked hospital units on the second floor. The rest home and hospital are mirror image have a large main

Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		lounge with a dining area and kitchenette. The large main lounges have seating placed to allow for individual or group activities. Each dementia care unit has an open plan lounge and separate dining room with a safe kitchenette area. The spacious open plan area allows for quiet areas and group activities. The open-plan living areas and hallways are spacious and allow maximum freedom of movement while promoting the safety of residents who are likely to wander. The dining room from both units have doors that open out to the courtyard of the other unit. Each serviced apartment has its own lounge and there is access to communal areas for serviced apartment residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The external chemical provider monitors the effectiveness of chemicals in the cleaning and laundry service. Manuals are provided on usage of chemicals and datasheets are visible. The service has a secure area for the storage of cleaning and laundry chemicals. Laundry chemicals are within a closed system to the washing machine. Laundry and cleaning audits were completed as per the Ryman programme. The spacious laundry had an entry and exit door with defined clean/dirty areas. All linen and personal clothing is laundered on-site. Linen is transported to the laundry in covered linen trolleys. There are dedicated cleaning and laundry staff on duty each day. 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. Cleaning trolleys are kept in locked designated areas when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	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. 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 1 June 2017. 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 resident's rooms, lounge areas and toilets/bathrooms. Serviced apartments have a call bell system, which is linked to staff pagers. Staff advised that they conduct security checks inside at night, in addition to an external contractor who checks the external. A security camera is installed at the entrance. There is a staff member with a first aid certificate on duty at all times.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately ventilated and heated with underfloor heating. There is air-conditioning in communal areas and resident bedrooms. All resident rooms and communal areas have external windows with plenty of natural sunlight.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	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 set out annually from head office and directed via the quality programme. The programme has not yet been operating for a full year but a six-month analysis was completed by the infection control and prevention officer (clinical manager) which is reported to the governing body. Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers and signage throughout the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	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 external infection control education. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, local laboratory and expertise from within the organisation.
Standard 3.3: Policies and procedures	FA	There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and

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.		control policies link to other documentation and cross reference where appropriate.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection 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. All staff complete hand hygiene audits. Infection control is an agenda item on the full facility and clinical meeting agenda. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. An outbreak involving 42 staff and residents in July 2017 was managed.
Standard 2.1.1: Restraint minimisation	FA	Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraints and no residents

Services demonstrate that the use of restraint is actively minimised.		using an enabler. Staff training has been provided around restraint minimisation.

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 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet	PA Low	Files sampled demonstrated that initial risk assessments were completed on admission within the required timeframes, as were initial care plans. All residents were seen by the GP within two working days of admission unless they were admitted from hospital, however, not all long-term care plans and interRAI assessments were completed within required timeframes or when there has been a change in resident condition. The triggers flagged in the interRAI assessments were planned for in long-term care plans, and on myRyman system in the interventions. InterRAI assessments of residents who have been in the facility for more than six months have had the interRAI assessment updated.	(i)One rest home level resident did not have an initial interRAI assessment completed until five weeks after admission. The long-term care plan was not completed within three weeks of admission and there was no interRAI reassessment completed when the same resident had a significant change of needs despite a referral to NASC for reassessment. (ii) one rest home resident in the serviced apartment did not have an interRAI completed within 21 days.	Ensure all long-term care plans and interRAI assessments are completed within the required timeframes, and updated to reflect progression or decline on resident

the needs of the consumer.				condition. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Progress notes are completed by care staff, registered nurses and other members of the MDT involved in resident care, such as Nurse Maude nurses for specialist wound care. Progress notes and tasks completed in the care centre (rest home, hospital and dementia units) are on the myRyman system and are completed on the surface device in each resident's room. Progress note comments are documented following completing tasks where required by both RNs and caregivers. No comments are written where residents are stable and routine tasks are completed. For rest home residents in the serviced apartments resident files, including progress notes are paper based. The rest home resident file reviewed in the serviced apartment identified that progress notes were intermittent and were not routinely completed where there was a health status change. The sample was increased to review progress notes of a further rest home resident in serviced apartments. These progress notes were also not regularly documented and did not describe the resident on admission.	(i)In the respite (rest home level) resident file sampled from the serviced apartments, the initial progress notes lacked detail about the resident and any potential risks. (ii)Two long-term rest home level residents in the serviced apartments had gaps of up to six weeks with no progress notes written, including following documented medical concerns.	Ensure all progress notes are completed in a timely manner and are reflective of resident condition including progression or decline. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed	PA Low	Wound assessments, plan and evaluations are completed at each dressing change and recorded in the myRyman system. Wound care documentation was being maintained for all current wounds but had not been completed for a now resolved pressure injury for the latter part of the treatment. Despite the lack of documentation, the previously unstageable pressure injury had healed so the risk has been assessed as low because it relates to documentation, not interventions. MyRyman system is designed to incorporate short or long-term changes to resident needs. Overall, this has occurred in the files sample. Not all long-term care plans or myRyman plans were updated to reflect changes in resident status following incidents.	(i)One hospital resident with a resolved unstageable pressure injury had no documentation that could be located for wound care between 19 June 2017 and 2 August 2017 (ii) Seven of nine incident forms from July 2017 where the investigation identified that an update to the care plan was required, did not have the care plan updated.	(i)Ensure there is documented evidence of wound care assessments, plans and evaluation for all wounds. (ii)Ensure care plans are updated when an

needs, and desired outcomes.				incident investigation identifies this is required. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.