

Charles Upham Retirement Village Limited - Charles Upham Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

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| 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: 12 March 2019 End date: 13 March 2019 |
| Proposed changes to current services (if any): | The service has converted two large premium room to doubles for couples, increasing the total number of beds to 122 in the care centre |

Total beds occupied across all premises included in the audit on the first day of the audit: 124

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 |
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|  | 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 |
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| 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

Ryman Charles Upham opened in November 2016 and provides rest home, hospital and dementia level care for up to 122 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 124 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, general practitioner (GP) and staff.

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 two years (since prior to the opening of the care centre). She is supported by a clinical manager who has three years' experience in Ryman facilities and previous age care experience. The residents and relatives interviewed all spoke positively about the care and support provided.

The three previous audit shortfalls have been addressed. These were around timeliness of documentation, progress notes, wound documentation and updating care plans when needs change. This audit identified a shortfall around medications.

Consumer rights

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| 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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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 system for the management of complaints. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. .

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant 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 plan 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

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrated service integration. Residents and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in 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 Engage programme meets the abilities and recreational needs of the group 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 the dementia care unit.

Safe and appropriate environment

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| 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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A current building warrant of fitness is posted in a visible location. Hazards during the building repairs are identified, documented and managed. There is a preventative and reactive maintenance schedule in place. Outdoor areas are well maintained and easily accessible. Indoor areas are light and spacious with room for residents to move around freely with mobility aids.

Restraint minimisation and safe practice

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| 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 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 has integrated meetings with the health and safety team. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs, and a six-monthly comparative summary is completed. An outbreak in March 2018 was well managed.

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) |
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| Standards | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 40 | 0 | 1 | 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) |
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| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are 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 12 complaints received since January 2018 to date. These were reviewed, and all were documented as resolved. Corrective actions have been implemented and any changes required were made because of the complaint. The service is currently assisting with an HDC complaint, all information that has been requested has been provided.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p> | FA | <p>An open disclosure policy describes ways that information is provided to residents and families. Regular contact is maintained with family including if an incident or health issue arises. Evidence of families being kept informed is documented on the myRyman electronic database and in the residents' progress notes. All relatives interviewed (one from special care unit, and three hospital) and residents interviewed (six rest home including the resident on respite and four hospital), stated they were well-informed. Twelve incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted. Regular resident and relative 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.</p> |

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| conducive to effective communication. | | |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Charles 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 124 residents in total, including six rest home level of care and one rest home respite care residents in the serviced apartments.</p> <p>All rooms in the rest home (level one) and the hospital (level two) are dual-purpose. There were 36 (of 40) residents on level one – all rest home level care (including one married couple in a double room). On level two there were 41 (of 40) residents); including one rest home level resident (married couple one rest home and one hospital sharing a double room at their request). Both double rooms were viewed and were of adequate size for both resident needs. Overall bed numbers have increased in the care centre from 120 beds to 122 beds. The ground floor also has two secure 20-bed dementia units. These units had full occupancy. At the time of the audit the two units, which adjoin and have connecting doors were operating as one unit. The DHB is aware of this arrangement.,</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation-wide objectives are translated at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific village objectives 2019 and progress towards objectives is updated as part of the TeamRyman schedule. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and dementia care.</p> <p>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 since May 2018. The clinical manager has worked as a unit coordinator in rest home and hospital level care in Ryman facilities for two years and has a background in age care. The assistant manager (non -clinical) supports both the village and clinical managers in their roles. There are experienced unit coordinators in each area (registered nurses in the rest home, hospital and dementia units and an enrolled nurse in the serviced apartments). The team are also supported by a regional manager. The regional quality coordinator was present during the days of the audit. Ryman provide ongoing training for managers and clinical managers. The village and clinical manager has completed in excess of eight hours education in the last year.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p> | FA | <p>Charles Upham has implemented the quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the full 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.</p> |

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| <p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>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 been completed in February 2018 which shows overall satisfaction and recently completed the 2019 survey and are awaiting the result. The relative survey was completed in July 2018 and shows overall satisfaction. Corrective actions included improvements around the dining experience, and enhancing activities for the residents have been implemented.</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 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. Staff interviewed (nine registered nurses, eleven caregivers, four activities staff, one maintenance, and one head chef) could describe internal audits which have been undertaken, and confirmed incident and infection data, health and safety and quality improvements are discussed at the appropriate meetings.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative (receptionist) has been appointed and she has completed the health and safety training NZQA L1&2. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The 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 the near miss register, the hazard register, and the maintenance register indicated that there is resolution of issues identified. The hazard register has been reviewed in November 2018.</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</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.</p> <p>A review of twelve 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 (RN, full facility, 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. A section 31 form was sighted for the reporting for the deep tissue injury</p> |

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| <p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>pressure injury.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, one serviced apartments unit coordinator (enrolled nurse), unit coordinator for hospital (also restraint coordinator), one RN from special care unit, three caregivers, one activities coordinator (from the special care 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.</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. Caregivers in the special care unit complete NZQU qualifications around dementia, currently there are 21 caregivers in the special care unit, nine have completed all four modules, four staff have previously completed the ACE programme and are in the process of completing the four modules. Eight staff have recently been employed, and have not yet started training. The caregivers in the rest of the facility complete annual Ryman competencies, 50 caregivers have completed a competency in 2019. Senior caregivers have completed medication competencies, and have a current first aid certificate.</p> <p>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 21 RNs working at Charles Upham, 16 RNs are interRAI trained.</p> <p>The clinical manager is one of six New Zealand members of the pressure injury prevention group and was nominated to present a case study at the STOP PI conference in November 2018.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> | <p>FA</p> | <p>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</p> |

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| <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>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.</p> <p>Staffing at Charles Upham is as follows:</p> <p>In the rest home unit on level one (36 rest home residents): ratio 1:10</p> <p>AM shift: Unit coordinator (RN) 7.30 am - 4.00 pm every day, with four caregivers; two long shifts (7.00 am -3.30 pm, and 7.00 am-3.00 pm), and two short shifts (7.00 am -1.00 pm and 8.00 am-1.00 pm). PM shift: Four caregivers - two caregivers one of which is a senior caregiver and medication competent work 3.00 pm to 11.00 pm, and two short shifts - 4.00 pm - 9.00 pm, and 5.00 pm - 8.30 pm. Night shift: Two caregivers one is a senior who is medication competent.</p> <p>In the hospital on level three (39 hospital level residents one rest home level resident): ratio1:5</p> <p>Unit coordinator (RN) five days a week. AM shift: Two registered nurses, eight caregivers; two caregivers 7.00 am to 3.30 pm, two caregivers 7.00 am - 3.00 pm, two caregivers 7.00 am – 1.00 pm, and two caregivers 8.00 am – 1.00 pm. A fluid assistant works from 9.30 am – 1.00 pm daily. The physiotherapy assistant works 9.00 am -12.00 midday five days a week. PM shift: Two registered nurses, two caregivers 3.00 pm - 11.00 pm, two caregivers 3.00 pm to 9.30 pm, two caregivers 4.00 pm – 9.00 pm, and one lounge caregiver 4.00 pm – 8.00 pm. Night shift: One registered nurse and three caregivers.</p> <p>Special care unit (dementia units): Both units have full occupancy of 20 residents each. Each unit is rostered separately. The lounge doors between the two units are open at various times during the day for group activities only. The doors are always closed during meals, and evening/night. There is RN cover in the unit across seven days including afternoon shifts.</p> <p>AM shift: Unit coordinator (RN) shared between the two units Sunday to Thursday. A registered nurse is rostered Friday and Saturday. A second RN is rostered seven days a week across the two units 0700 – 1530. There is also a registered nurse rostered 1530 – 2300 seven days a week. There is an activity and lifestyle coordinator (trained DT) rostered 0900 – 1800 across the two units.</p> <p>Special Care unit one, AM shift: one long shift 7.00 am - 3.30 pm and one short shift 7.00 am - 1.00 pm and a lounge assistant from 9.00 am – 4.00 pm (shared across the two units). PM shift: one long shift 3.00 pm - 11.00 pm, and shorter shift 3.00 pm - 9.00 pm, and a lounge assistant from 4.00 pm – 8.00 pm (shared across the two units). Night shift: one senior caregiver who is medication competent 10.45 pm - 7.15 am (shared across the two units), and one caregiver 11.00 pm – 7.00 am.</p> <p>Special Care unit two, AM shift: one long shift 7.00 am - 3.30 pm and one short shift 7.00 am - 1.00 pm and a lounge assistant from 9.00 am – 4.00 pm (shared across the two units). PM shift: one long shift 3.00 pm - 11.00 pm, and shorter shift 3.00 pm - 9.00 pm, and a lounge assistant from 4.00 pm – 8.00 pm (shared across the two units). Night shift: one senior caregiver who is medication competent 10.45 pm - 7.15 am (across the two units),</p> |
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| | | <p>and one caregiver 11.00 pm – 7.00 am.</p> <p>Serviced apartments: AM shift: Unit coordinator (EN) three days 8.30 am - 4.30 pm, senior caregiver on this shift the other two days, two caregivers one 7.00 am - 3.30 pm, and one 8.00 am - 1.00 pm, and one dining assistant from 9.00 am – 1.00 pm. PM shift: one caregiver 4.00 pm - 10.00 pm, and a dining assistant from 4.30 pm - 6.30 pm. The clinical manager supports the unit coordinator with checking of assessments and care plans. The unit coordinator from the rest home checks on the serviced apartments over the weekends. When there are no staff rostered in the serviced apartments (night) the staff in the rest home check on the residents and answer bells as confirmed by the clinical manager, and the unit coordinator.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | PA Low | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements and guidelines. Medication is stored and administered in accordance with current guidelines. Charles Upham uses an electronic medication management system. All medication fridges are temperature checked weekly and corrective actions documented where temperatures are outside the required range. Controlled medications are held securely in medication rooms in the rest home, hospital and special care unit. All controlled drug medication administration is documented in the controlled drug register; however, the time of administration is not always documented. On delivery of medication, an RN completes medication reconciliation and any errors fed back to pharmacy. 'As required' (PRN) medication expiry dates are checked monthly. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided.</p> <p>Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Standing orders are not used. There are currently two residents self-administering some of their medications. The resident's competencies are checked three monthly and a record signed by the GP is kept on file. Sixteen medication charts and electronic signing sheets were reviewed (six rest home [including two from the serviced apartments] and six hospital and four dementia care). Photo identification and allergy status were on all charts. All medication charts for long-term residents had been reviewed by the GP at least three monthly.</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</p> | FA | <p>All food and baking is prepared and cooked on-site in a well-appointed kitchen. The qualified head chef is supported by a weekend chef, cooks and kitchen assistants. Staff have been trained in food safety and chemical safety. There is a verified food control plan implemented due for renewal in May 2019. There is an organisational four-weekly seasonal menu that had been designed in consultation with the dietitian at organisational level. Meals are plated in the kitchen and delivered in hot boxes and served from the kitchenettes in each unit. Residents have a choice of three choices for the lunchtime main meal and two meal options for the evening meal.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food</p> |

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| <p>service is a component of service delivery.</p> | | <p>allergies are accommodated. Special diets such as pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia unit.</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 and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>The head chef participates in a chefs table occasion (weekly), where residents have the opportunity to sit with the chef and discuss their likes and dislikes. Residents also have the opportunity to participate in small group tours of the kitchen. Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the chef. Residents interviewed spoke positively about the food service.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, a registered nurse initiates a review and if required, a GP visit or nurse specialist consultant. 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, (eg, resident turns, fluids given). Care plans reviewed were updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections. The previous partial attainment has been addressed.</p> <p>Wound assessments, treatment and evaluations were in place (on the electronic database) for 15 residents with wounds (skin tears, lesions and chronic ulcers). There were two residents with facility acquired pressure injuries on the day of audit (one stage four [from previous audit] and one unstageable deep tissue injury). Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse or district nurses as required. The GP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans. The previous partial attainment has been addressed.</p> <p>Continence 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.</p> <p>Monitoring forms in place include (but are 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> |

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| <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 four activities staff members (including one qualified diversional therapist and one currently progressing through the diversional therapy level 4 training). Together they coordinate and implement the Engage programme across the four areas; rest home, serviced apartments, hospital and dementia care unit. Activity staff attend on-site and organisational in-service training relevant to their roles. All staff have current first aid certificates.</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 including Triple AAA exercises, walking groups, themes events and celebrations, indoor bowls, baking and cooking, games, entertainment, outings and drives. Activities are provided Monday to Sunday in all areas except the rest home. Rest home residents are welcome to join in the activities in the serviced apartments.</p> <p>Two vans are available for outings for all residents. Dementia unit residents have twice weekly outings. There are two garden courtyards in the secure units allowing for dementia residents to safely wander. Rest home residents in the serviced apartments attend the serviced apartment programme. The activities staff interviewed advised that they make daily contact with all residents and one-on-one time is spent with those residents who choose not to be involved in the activity programme. Community involvement includes local school visits, kapa haka group visits, entertainers and church services. The village and rest home are running kitchen tours and hosting a chefs table event where residents dine with the chef.</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 have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. Residents interviewed stated there were lots of available activities.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Electronic resident files reviewed identified that long-term care plans had been evaluated by registered nurses at least six-monthly or earlier as required. A written multidisciplinary review record is maintained that evidences family/resident involvement in the care plan evaluation process. Evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the myRyman care plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review. The multidisciplinary review involves the RN, clinical manager, GP, caregivers, activities staff 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> |

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| <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>There is a full-time maintenance officer who is also on call for urgent maintenance requirements. There are essential contractors available 24/7. The building holds a current warrant of fitness which expires on 30 January 2020. All requests are recorded in a register held at the main reception (sighted) which has been signed off as requests have been addressed. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, electrical testing (bi-annually) of electric beds and hoists and electrical testing. Hot water temperatures in resident areas are monitored three monthly as part of the environmental audit and stable below 45 degrees Celsius.</p> <p>Two double rooms were reviewed at this audit and were verified as suitable for couples.</p> <p>There are spacious communal lounges and wide corridors with safety rails. All rooms and communal areas allow for safe use of mobility equipment. Residents were observed moving freely around the areas with mobility aids where required. External areas and gardens provide paths seating and shade. Each dementia unit has a separate outdoor garden area off their lounge areas. Both outdoor areas are on the ground floor. The garden areas allow for wandering with well-designed paths and seating areas.</p> <p>Caregivers and registered nurses interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>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 myRyman 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 bi-monthly infection prevention and control/health and safety meetings. Staff are informed through the clinical meetings, and full facility meetings. 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.</p> <p>An outbreak involving 6 staff and 15 residents in March-April 2018 was managed appropriately, relevant notifications were made in a timely manner.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p> | <p>FA</p> | <p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraints and no residents using an enabler. Staff training has been provided around challenging behaviours, restraint minimisation, and use of enablers.</p> |

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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 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | The controlled drug register is completed for all controlled drug administration. The control drug registers in the hospital and dementia unit consistently record all details including the time of administration, however this was not always documented in the rest home. Noting, the electronic record does record the time of administration and therefore the risk has been identified as low. | Several entries in the rest home controlled drug register did not document the time of administration | Ensure the controlled drug register is fully documented as 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.