

# Bob Scott Retirement Village Limited - Bob Scott

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## 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:

<b>Legal entity:</b>	Bob Scott Retirement Village Limited
<b>Premises audited:</b>	Bob Scott
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 22 November 2018    End date: 23 November 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	107

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Bob Scott provides rest home, dementia and hospital level care for up to 145 residents (including rest home level care across 30 serviced apartments). At the time of the audit there were 107 residents in total.

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

The village manager at Bob Scott has been in the role for one year and has 10 years of management experience at another Ryman facility. She is supported by an assistant to the manager and a clinical manager. The clinical manager been in the position for two years and has worked at Bob Scott for three years. The management team is supported by the Ryman management team including regional manager.

The service has addressed the three of four findings from the previous audit around meetings, interRAI assessments and an aspect of medication. There continues to be an improvement required care plan intervention.

This audit identified one improvement required around pain management.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Relative and resident meetings are held regularly. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant to the manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. Bob Scott has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Bob Scott provides clinical indicator data for the three services being provided (rest home, dementia and hospital). There are human resources policies including recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are evaluated at least six monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP. The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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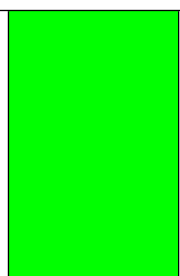
There is a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers, as evidenced in the two resident files with restraints reviewed. At the time of the audit there were no residents using any enablers and one resident with a restraint in use. Staff receive training around restraint minimisation and enabler use.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities. There have been no outbreaks.

## 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)
<b>Standards</b>	0	16	0	0	1	0	0
<b>Criteria</b>	0	42	0	0	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy is being implemented at Bob Scott facility. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and operations manager are involved in clinical complaints. The facility has an up-to-date complaint register for each unit. Concerns and complaints are discussed at relevant meetings. There have been 16 complaints made in 2017 since the last audit and 16 complaints received in 2018 year to date.</p> <p>There was documented evidence of internal investigations and family meetings with resolution for all complaints. Complaints have been acknowledged and addressed within the required timeframes. Two of the complaints in 2018 were made through the HDC; the service has completed investigations for both complaints with no further action required for one of the complaints, an HDC letter on 26 October 2018 confirming this and the other complaint is ongoing, as the service are awaiting a response from HDC to a follow-up letter dated 12 August 2018.</p> <p>The Ministry requested follow up against aspects of a complaint that included advanced care planning. This audit has not identified issues around advanced care planning; however, shortfalls were identified around pain management (link 1.3.5.2)</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Twelve incident forms reviewed for October 2018 evidenced the family had</p>



<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>been informed of the accident/incident. Five relatives (one rest home, two hospital and two dementia care) interviewed, stated that they are informed when their family members health status changes. Six monthly relative meetings occur in each of the units (rest home, hospital and dementia care). Six residents (all rest home including one in the serviced apartments) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Specific introduction information is available on the dementia unit for family, friends and visitors to the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Bob Scott is a Ryman healthcare retirement village providing rest home, hospital and dementia level care for up to 145 residents. The facility is across five levels, which includes 34 rest home level beds on level four, 41 dual-purpose beds (hospital and rest home) on level three and 40 dementia level beds (two 20 bed wings) on level two. The service has 30 serviced apartments certified as able to provide rest home level care. Level one and level five are serviced apartments only. There was one resident receiving rest home care in the serviced apartments at the time of the audit. Occupancy during the audit was 107 residents in total, 38 rest home level residents (including five in the dual-purpose beds and one in the serviced apartments), 34 hospital level residents, including two residents on respite care and one resident on a younger person with disabilities (YPD) contract and 35 residents in the dementia unit.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation-wide objectives are translated at each Ryman service by way of the teamRyman programme that includes a schedule across the year. The village quality objectives and quality initiatives for 2018 have been set with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2018 objectives.</p> <p>The village manager at Bob Scott has been in the role for one year and has ten years of management experience at another Ryman facility. She is supported by an assistant to the manager, who carries out administrative functions, and a clinical manager who oversees clinical care and support for the village manager. The clinical manager been in the position for two years and has worked at Bob Scott for three years. The managers are supported by a unit coordinator in each unit. The management team is also supported by the Ryman management team including the regional manager. The regional manager was present on the days of the audit.</p> <p>The village manager attends the annual Ryman managers' conference and manager forums and the clinical manager has attended a Ryman leadership programme and clinical seminars in 2018.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Bob Scott has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. The meeting schedule has been adhered to and any required actions are followed up or completed. The previous finding around staff meetings has now been addressed. Discussions with the management team and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Audit summaries and quality improvement plans (QIP) are completed where a non-compliance is identified. QIPs reviewed for 2017 and 2018 have been closed out once resolved. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Bob Scott provides clinical indicator data for the three services being provided (rest home, dementia and hospital). Clinical indicators are graphed and displayed in the staff room, showing trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes. A resident/relative satisfaction survey was completed in July 2018 with a positive overall satisfaction outcome. Quality improvement plans evidenced that suggestions and concerns were addressed around laundry, activities and food services.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (facility manager) was interviewed. He has completed specific external health and safety training. Health and safety/infection control meetings are conducted bi-monthly. 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 management, teamRyman and staff meetings. Falls prevention strategies are in place that include; ongoing falls assessment, routine checks of all residents specific to each resident's needs (intentional rounding), encouraging resident participation in the activities programme and the use of sensor mats.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of twelve incident/accidents forms identified timely RN review and follow-up. Neurological observations were completed for four resident falls reviewed for unwitnessed falls or with potential head injury. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>meetings. This provides the opportunity to review any incidents as they occur.</p> <p>The village manager and clinical manager were able to identify situations that would be reported to statutory authorities. Four section 31 notification reports were sighted since the last audit for one stage three pressure injury in September 2018 and two unstageable pressure injuries in August and September 2018 and one police investigation (missing resident) in July 2108.</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 human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical manager, one unit-coordinator, one RN, three caregivers and one activities coordinator) included a signed contract, job description relevant to the staff members role, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for three newly appointed staff. A register of RN practising certificates is maintained. Practising certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan in place for 2018 and exceeds eight hours annually. There is an individual staff member record of training. Staff are also required to complete a series of comprehension surveys each year. Registered nurses (RN) are supported to maintain their professional competency. Ten of fourteen RNs have completed their interRAI training. There are implemented competencies specific to RNs and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies. There are eighteen caregivers who work in the dementia unit. Twelve caregivers have completed the dementia standards and the six caregivers in progress of completing have commenced work in the last 18 months. A QIP is in place to ensure that the training is completed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service</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 fulltime Monday to Friday and are on call 24/7. The rest home, hospital and dementia units in the care centre has a RN unit coordinator and the certified serviced apartments for rest home level care has a EN unit coordinator. There is at least one RN and first aid trained member of staff on every shift. Interviews with caregivers informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated that overall there was sufficient staff to meet resident needs.</p> <p>Staffing at Bob Scott is as follows: In the hospital unit (41 beds) on level three, there were 34 hospital and five rest home residents. There is a unit coordinator/RN who is supported by two RNs on duty on the morning and afternoon</p>

<p>providers.</p>		<p>shifts, and one RN on night shift. There are eight caregivers (four long and four short shifts) and a fluids assistant on the morning shift, seven caregivers (three long and four short shifts) and three caregivers on night shift. I</p> <p>In the rest home unit (34 beds) on level four, there are 32 rest home residents. There is a unit coordinator/RN who is supported by four caregivers (two long and two short shifts) and on the morning and afternoon shifts, and two caregivers on the night shift. The RNs in the hospital oversee the rest home unit on the afternoon and night shifts.</p> <p>In the dementia unit (40 beds, two wings of 20) on level two, there were 35 dementia residents. There is a unit coordinator/RN who is supported by one RN on duty on the morning and afternoon shifts. They are supported by four caregivers (two long and two short shifts) on the morning shift, five caregivers (two long and three short shifts) and three caregivers on night shift. The RNs in the hospital oversee the dementia unit on the night shift.</p> <p>In the serviced apartments (30 beds) there was one rest home level resident. There is a unit coordinator/EN who is supported by two caregivers (one long and one short shift) on the morning shift and three caregivers (one long and two short shifts) on the afternoon shift. The rest home caregivers and hospital RN cover the serviced apartments on the night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. Registered nurses, enrolled nurse and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (hospital, rest home, dementia care unit and serviced apartments). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication fridges are checked daily, and temperatures sighted were within the acceptable range. There was one rest home resident and three hospital level residents self-medicating on the day of audit.</p> <p>Medications were stored safely in the residents' rooms. Three monthly self-medication competencies had been completed by the RN and authorised by the GP. Twelve medication charts on the electronic medication system and two paper-based medication charts (of respite residents) were reviewed. All charts identified an allergy status. All long-term resident charts on the electronic system had photo identification. Medication charts for long-term residents had been reviewed at least three monthly by the GP. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. There were no residents prescribed oxygen on the day of audit. The previous finding around oxygen prescribing has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	<p>FA</p>	<p>The head chef is supported by an evening chef, cook's assistants and kitchenhands/dishwashers. All have completed food safety and hygiene training. The head chef oversees the procurement of the food and</p>

<p>And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>management of the kitchen. The food control plan has been verified and expires 9 May 2019. The project delicious menus have been reviewed by a dietitian. The menu provides three options including a vegetarian option for the midday meal and dinner. The meals are plated in the kitchen and transported to the unit kitchenettes in hot boxes. Changes to residents' dietary needs are communicated to the kitchen.</p> <p>Special diets and likes and dislikes were known. Special equipment such as lipped plates are available. There are protein platters and snacks available at all times in the dementia unit. Kitchen fridge and freezer temperatures were monitored and recorded twice daily. End-cooked food temperatures and serving temperatures are monitored and recorded. Residents and family members interviewed were satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings, food comment books and surveys. Management liaise regularly with the head chef to monitor feedback and identify any areas for improvement.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs as assessed through the interRAI assessments and risk assessment tools and provide detail to guide care, however two residents with new pain did not have a pain management plan in place. The previous finding around pain management remains. There was a behaviour management plan in the two files of dementia care residents that included interventions and strategies for de-escalation including activities.</p> <p>MyRyman care plans are updated when there are changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, wound nurse specialist and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.</p> <p>Ryman complete advance care planning section of the Vcare plans as sighted in the long-term files.</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>When a resident's condition changes the RN initiates a GP or nurse specialist consultation. Two RN unit coordinators, one enrolled nurse unit coordinator and two RNs interviewed stated that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to the health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. Care plans overall have been updated as residents' needs changed (link 1.3.5.2). Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are documented electronically, and wound monitoring occurs as planned in the sample of wounds reviewed.</p> <p>There are currently four facility acquired pressure injuries, including two stage two and two stage one pressure</p>

		<p>injuries. A RN in the hospital is the wound nurse champion for the facility and reviews wounds regularly. There is access to a wound nurse specialist as required. Photos of wounds demonstrate healing progress. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position and pressure cares electronically. Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A team of activity officers (all qualified diversional therapists – DT), activity assistants and lounge carers implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The activity team (DT) implement a Monday to Friday programme in the rest home and a seven-day programme in the hospital and the two dementia care units. The dementia care DT is supported by a lounge carer to enable activities to be provided across both units. There is a weekly programme for each unit in large print on noticeboards and some residents also have a copy in their rooms. Residents have the choice of a variety of engage activities in which to participate, including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts, happy hours, baking, men’s group and activities and walks/wheelchair walks outside for less independent residents.</p> <p>Rest home residents were observed to be independently using the lift to visit the café and walks in the gardens. Residents in the dementia care unit are taken on supervised walks in the mornings and afternoons. The rest home resident in a serviced apartment can choose to attend the serviced apartment or rest home activity programme. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There are volunteers from the village involved in activities such as scrabble and one-on-one time with residents. There are integrated activities and combined church services. Themes and events are celebrated. Community visitors include mother and baby groups, pre-school children, musical entertainers, kapa haka group and beauty therapy students.</p> <p>The service hires a mobility van for hospital outings. The service has a van for the rest home and dementia care outings. Residents attend functions in the community and visit places of interest including scenic drives. Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.</p>
Standard 1.3.8:	FA	Six long-term resident care plans had been evaluated by the RNs six monthly or when changes to care occurs.

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>One hospital level resident had not been at the service long enough for an evaluation. The respite care resident does not require an evaluation of care. The multidisciplinary review involves the RN, GP, CG, DT and resident/family if they wish to attend and any other allied health professional involved in the resident's care such as the physiotherapist. There are three-monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 15 March 2019. There is a reactive and planned maintenance programme.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control officer (clinical manager) completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the monthly combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and toolbox talks. There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. At the time of the audit there were no residents using any enablers and one hospital resident with restraint in use (chair brief). Staff receive training around restraint minimisation and enabler use.</p>





## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Care plans reviewed evidenced documented interventions for the management of pressure injury risk, prevention of weight loss, falls prevention interventions, behaviour management and pain management for chronic pain, however there were no documented interventions for two residents with new pain.</p>	<p>There were no pain assessments or documented pain management plans for two residents (one rest home and one dementia care) who required GPs visits and analgesia.</p>	<p>Ensure long-term care plans are updated to include interventions for pain management.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.