

Grace Joel Retirement Village Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Grace Joel Retirement Village Limited
Premises audited:	Grace Joel Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 July 2015 End date: 7 July 2015
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:	97

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Grace Joel is part of the Ryman group and provides rest home and hospital level care for up to 127 residents. On the day of audit, there were 97 residents. The service is managed by a village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

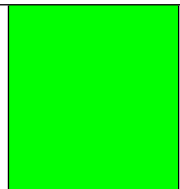
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews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

There were no shortfalls from the previous certification audit.

This surveillance audit identified that no improvements are required.

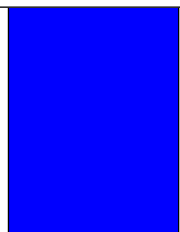
An area of continuous improvement is identified around the evaluation of implemented corrective action plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families are kept informed. Residents and their family/whanau are provided with information on the complaints process on admission. Complaints are being managed in a timely manner. Staff are aware of the complaints process and to whom they should direct 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.		All standards applicable to this service fully attained with some standards exceeded.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations of the service. Goals are documented for the service with evidence of annual reviews. Corrective actions are implemented and evaluated where opportunities for improvements are identified. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. On-going education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nursing staff are responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home and hospital residents. Spiritual and cultural preferences and needs are being met.

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications completes education and medication competencies. The medication charts reviewed meet prescribing requirements and were reviewed at least three monthly

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. All kitchen staff are trained in food safety and hygiene.

Safe and appropriate environment

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

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service currently has no residents assessed as requiring the use of restraint and four residents requiring enablers.

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 type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events.

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	1	15	0	0	0	0	0
Criteria	1	38	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all seven residents (four hospital level and three rest home level with two residents in the serviced apartments) and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that includes written and verbal complaints, dates and actions taken and evidences that complaints are being managed in a timely manner. Twelve complaints were lodged in 2015 (year to date). There was evidence of complaints received being managed appropriately, communicated to staff and management and documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>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 that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. Evidence of families being kept informed is documented on the electronic database (V-care) and in the residents' progress notes. All four family interviewed (two with family at rest home level and two with family at hospital level) stated they were well-</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>informed. Ten 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.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. The information pack is available in large print and in other languages. It is read to residents who are visually impaired.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>Grace Joel is a Ryman healthcare retirement village located in St Heliers, Auckland. The care centre is modern and spacious. The facility is built across five floors and is designed around a large atrium and courtyards with the rest home on level one and the hospital beds on level two. It provides rest home and hospital level care for up to 107 residents. Additionally, there are 80 serviced apartments with 20 certified to be able to provide rest home level care. Occupancy during the audit was 42 rest home level residents (including nine in the serviced departments) and 55 hospital level residents. There were no residents under the medical component and no respite residents.</p> <p>There is a documented service philosophy set at head office that guides quality improvement and risk management in the service. Specific values have been determined for the facility. Organisational objectives for 2015 are defined 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 2015 objectives.</p> <p>The village manager began employment at Grace Joel in December 2014. He has an accounting background in manufacturing. His induction programme was extensive, including spending two weeks at two other Ryman facilities, and has attended Ryman village manager days and the Ryman conference. He has attended over eight hours (year to date) of professional development activities related to managing an aged care facility.</p> <p>The village manager is supported by the regional manager and the systems manager. He is also supported by an assistant village manager who has five years of experience in administration and quality in other Ryman facilities, provides facilitation for the quality and risk management programme and has been in at Grace Joel for two years. A clinical manager/registered nurse oversee clinical care for all residents and coordinate the rest home level of care. A hospital coordinator/RN is responsible for the hospital level residents.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>CI</p>	<p>Grace Joel has a well-established quality and risk management system that is directed by head office. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers (village manager, assistant village manager, clinical manager/registered nurse (RN)) and staff (one hospital coordinator/RN, five registered nurses (two hospital, two rest home and one serviced</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>apartments), twelve caregivers (six hospital, five rest home and one serviced apartments) and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.</p> <p>Resident meetings are held two monthly in the rest home and in the hospital. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed annually. Action plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies and 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 Ryman accreditation programme (RAP) calendar. They are communicated to staff, evidenced in staff meeting minutes. Recent updates to policies and procedures include procedures around the implementation of InterRAI.</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. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings that also include review of infection control and of incidents. A health and safety officer has been appointed. 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 meetings held in the facility including minutes of the monthly RAP committee meetings, registered nurse/enrolled nurse meetings, two monthly health and safety meetings and monthly full facility meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice to March 2016.</p> <p>Falls prevention strategies are in place including the recent quality initiative of identifying residents at risk of falling while using their mobility equipment. Other initiatives include regular hourly checks of all residents, use of sensor mats, physiotherapy assessments by a qualified physiotherapist and regular physiotherapy treatments, provided by a physiotherapy assistant.</p> <p>The hazard identification resolution plan is sent to head office and identifies any key hazards that are identified. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.</p> <p>The two monthly journal club (attended by registered/enrolled nurses), directed by head office, reviews the latest clinical practice articles. Topics that have been covered include topics relevant to service delivery.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>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 ten incident/accident forms for the facility identifies that all are fully completed and include follow-up by a registered nurse. The village manager and assistant manager are involved in the adverse event process with the weekly management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify that the following situations would be reported to statutory authorities including infectious diseases; serious accidents; unexpected death; specific situations to the MoH, and changes in managers.</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. Eight staff files reviewed (four caregivers, two registered nurses, one hospital coordinator/RN, one activities assistant) included a signed contract, job description relevant to the role the staff member is in, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of registered nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. The orientation/induction training for caregivers, on completion, provides them with a level two national certificate in support of the older person.</p> <p>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. Evaluations are completed for all training provided. Registered nurses are supported to maintain their professional competency. Four registered nurses have completed their InterRAI training, meeting contractual requirements. Staff training records are maintained. The journal club for registered nurses and enrolled nurses meets two monthly. There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including medication competencies and insulin competencies.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>Staff on the floor on the days of the audit was visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</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 safe medicine management that meet legislative requirements. The service uses individualised medication blister packs for regular and as needed (PRN) medications. Medications are managed appropriately in line with required guidelines and legislation. Medication reconciliation is completed on delivery of medications and the signing sheet is signed by the RN checking the medications. There are weekly and six monthly controlled drug checks. All clinical staff who administers medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Two hospital RN's have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are in use. Three self-medicating residents had been assessed by the GP and RN as competent to self-administer.</p> <p>All 12 medication charts sampled (six rest home and six hospital) met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident 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 service is a component of service</p>	<p>FA</p>	<p>The meals at Grace Joel are all prepared on site. There is a four weekly seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The cook receives resident dietary information from the RN's and is notified of any changes to dietary requirements (vegetarian, moulid foods) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences.</p> <p>Food safety management procedures are adhered to including storage of food, and temperature monitoring. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses.</p>

delivery.		The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys.
<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>	FA	<p>One hospital resident admitted since 1 July 2015 has commenced the InterRAI assessments required for the development of the long term care plan. Five RN's are competent in the use of the InterRAI assessment tool. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. Six of six long term care plans reviewed evidenced that interventions are fully recorded and align with the resident's assessed needs.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds, (six skin lesions, four skin tears, two chronic wounds). There are two residents with pressure areas (grade 2). Pressure area prevention strategies are included in the long term care plan. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The Ryman wound care nurse specialist (interviewed) reviews all wound care documentation weekly and regularly assesses all complex wounds with the registered nurses. Staff receive regular education on wound management from the Ryman wound care nurse specialist.</p> <p>Short term care plans are utilised for short term care issues including changes in health conditions, infections and wounds.</p> <p>Continence products are available and resident files include a 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 care staff interviewed.</p> <p>The clinical files sampled evidenced involvement of referral to allied health and specialist serves as required including speech language therapist, physiotherapist, dietician, skin specialist, podiatrist, and wound care specialist.</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</p>	FA	<p>There are six activity co-ordinators who provide a separate Monday to Friday activity programme for the rest home/hospital and serviced apartments. A company diversional therapist (DT) oversees the activity programmes. The activity co-ordinators attend Ryman workshops and on-site in-services. All hold a current first aid certificate. Two of the activity team have commenced training towards DT qualifications. The programme is planned monthly and includes Ryman minimum requirements for the "Engage" activities programme. Activities programmes are displayed on notice boards around the facility and a monthly calendar is delivered to each individual resident. There is a core programme which includes the triple A (Active, Ageless, Awareness) exercise programme. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One on one time is spent with residents who are unable to actively participate in the activities. Residents in serviced apartments can choose to attend the serviced apartment or rest home/hospital activities. Entertainment and outing are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if</p>

service.		applicable, and likes, dislikes, and hobbies are discussed. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment and outings. Resident meetings are held two monthly and family meetings six monthly. There is an opportunity to provide feedback on activities at the meetings and six monthly reviews. Resident and relative surveys also provide feedback on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The evaluation and care plan review policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. All files sampled contained written evaluations completed six monthly. Family are invited to attend review meetings (correspondence noted in files reviewed). The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. On- going nursing evaluations occur daily and/or as required and are documented in the progress notes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A service displays a current building warrant of fitness (expiry date: 3 March 2016).
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	FA	<p>The surveillance programme is organised and promoted via the Ryman accreditation programme calendar. Effective monitoring is the responsibility of the infection prevention and control officer who is a registered nurse. An individual infection report form is completed for all each infections. Data is logged into V Care, which gives a monthly infection summary. This summary is then discussed at the bimonthly combined health and safety and infection prevention and control (IPC) meetings. Three monthly and six monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Grace Joel include discussion on infection prevention control. Infection rates are benchmarked across the organisation.</p> <p>There has been one outbreak of infection within the facility since the previous audit. The outbreak was managed according to the MOH guidelines for the management of outbreaks and all reporting requirements were met.</p>

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation manual applicable to the type and size of the service. 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 enablers.</p> <p>There were four residents using enablers and no residents with restraints during the audit. One resident file was reviewed where an enabler (bedrails) was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>A comprehensive corrective action planning process is in place that is linked to the Ryman quality improvement plan (QIP) process.</p>	<p>The comprehensive corrective action planning process includes documented evidence of an action plan that reflects a review process, including the analysis and reporting of findings and dates of post-implementation evaluation and review; documented evidence of actions taken based on findings and improvement to service provision; and documented evidence of how resident safety has been measured as a result of the review process. One example relates to an internal spot surveillance audit conducted in March 2015, identifying shortfalls relating to incomplete residents' long term care plans. Actions undertaken included discussing findings with staff; two education and training sessions for the registered nursing staff, and re-auditing care plans. Results reflected evidence of 100% compliance for completing long term care plans within acceptable time frames. Another example relates to reducing restraint use. In May 2013, there were 7907 hours recorded of resident's in restraint. Actions to reduce the need for restraints included reassessing each resident using restraint, obtaining consent for the release of restraint, and implementing initiatives to manage residents in a restraint-free environment including intentional rounding, colour tagging walking aids, use of low beds, and utilising sensor mats. The facility has been restraint free for 2015 without a spike in the number of residents' falls.</p>

End of the report.