

Julia Wallace 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:	Julia Wallace Retirement Village Limited
Premises audited:	Julia Wallace 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: 25 October 2016 End date: 26 October 2016
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:	87

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Julia Wallace is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital and dementia level of care for up to 84 residents in the care centre and rest home level of care for up to 20 residents in serviced apartments. On the day of audit there were 87 residents including six rest home residents in the serviced apartments. The service is managed by an experienced non-clinical village manager, an assistant manager and an experienced clinical manager. The residents and relatives interviewed 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, staff and the general practitioner.

The previous finding around interventions remains. There were no new findings at this surveillance audit.

A continuous improvement rating has been maintained around activities and a continuous improvement rating awarded for reduction of falls.

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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Full information is provided at entry to residents and family/representatives. Communication with residents and families is appropriately managed and documented. 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. There are bi-monthly resident meetings and six monthly relative meetings held. Complaints are actioned and include documented response to complainants. A complaints register is maintained in VCare.

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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Julia Wallace retirement village has implemented the 'TeamRyman' programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including various staff meetings. Annual resident/relative satisfaction surveys have been completed. Quality and risk performance has been reported across the various facility meetings and to the organisation's management team. Julia Wallace provides clinical indicator data for the three services being provided (hospital, rest home and dementia care). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation 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 was supported. The organisational staffing policy aligns with contractual requirements and included skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate 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 admission visits and reviews the residents at least three monthly.

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

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

The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in the dementia care unit.

Safe and appropriate environment

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

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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There are policies and procedures on safe restraint use and enablers. There were five residents voluntarily using six enablers (five bedrails and one chair brief) and four residents with five restraints (two bedrails and three chair briefs). The clinical manager/registered nurse is the restraint coordinator. Staff receive training around restraint and challenging behaviours.

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 prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs. 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)
Standards	1	14	0	1	0	0	0
Criteria	2	36	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)
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 complaints policy and supporting documents are being implemented. The village manager has the overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. The number of complaints received each month is reported to staff via the various staff meetings. A complaints register has been maintained in VCare that includes relevant information regarding the complaint. There have been seven documented complaints made in 2016 year to date and sixteen complaints made in 2015 since the last audit. Follow-up letters, investigation and outcomes have been documented. Discussion with residents and relatives confirmed they were provided with information on the complaints process. Complaints information is provided on admission.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Full information is provided at entry to residents and family/representatives. Eight residents (five rest home and three hospital) and two relatives (one hospital and one dementia) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. A sample of incident forms reviewed for October 2016 identified that family were notified following a resident incident.</p> <p>Relatives interviewed confirmed they were notified of any changes in their family member's health status. Interpreter policy and contact details of interpreters are available. Non-Subsidised residents are advised in writing</p>

<p>conducive to effective communication.</p>		<p>of their eligibility and the process to become a subsidised resident should they wish to do so. The information pack is available in large print and this can be read to residents. A specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. Bi-monthly resident meetings and six monthly relative meetings are held.</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>Julia Wallace Retirement Village is a Ryman Healthcare facility, situated in Palmerston North. The service is able to provide care for up to 104 residents. This includes 84 resident rooms in the care centre at hospital, rest home and dementia level care; and 20 serviced apartments that have been certified for rest home level care. At the time of the audit, there were 29 rest home residents (including six rest home residents in the serviced apartments) and 37 hospital level residents. There were 21 (of 21 beds) dementia level residents in the special care unit. All beds in the care centre are dual-purpose. There are no residents under a medical component, younger persons or any residents on respite. All residents were under the ARCC agreement.</p> <p>The village manager is non-clinical and has been in the role for three and a half years. She is a qualified medical microbiologist and haematologist with previous management experience. She is supported by an assistant manager who carries out administrative duties. A clinical manager (registered nurse) oversees the clinical care in the care centre. The clinical manager commenced the role in July 2016 and has over 10 years' experience in the aged care industry. Each of the hospital, rest home and dementia care units are managed by registered nurse coordinators. The serviced apartments are coordinated by an enrolled nurse. The management team is supported by the Ryman management team including a regional operations manager. The village manager attends the annual Ryman managers' conference.</p> <p>The village manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</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</p>	<p>FA</p>	<p>Julia Wallace service continues to implement the TeamRyman programme, which links key components of the quality management system to village operations. There are monthly TeamRyman committee meetings. Outcomes from the TeamRyman committee are then reported across the various meetings including the full facility, registered nurse (RN) and care assistants. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Clinical meeting minutes were sighted. Interviews with staff confirmed an understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence. Care staff stated they are made aware of any new/reviewed policies and</p>

improvement principles.		<p>these are available in the staff room.</p> <p>A relative survey was last completed in March 2016, serviced apartment residents survey in June 2016 and care residents survey in February 2016. Results have been collated with annual comparisons for each service. Areas of concern were identified and quality improvement plans raised (QIPs), completed and signed off. Results were fed back to participants through resident and relative meetings. TeamRyman prescribes the annual internal audit schedule that has been implemented at Julia Wallace. Audit summaries and QIPs are completed where a non-compliance is identified (<90%). Issues and outcomes are reported to the appropriate committee (eg, health and safety). Quality improvement plans reviewed are seen to have been closed out once resolved.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is trending of clinical data and development of QIPs when volumes exceed targets (eg, falls). The service has reduced falls across the service levels and has achieved a continuous improvement rating in this area. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The health and safety and infection control committee meet bi-monthly and incidents/accidents, falls and infections is discussed and documented. The health and safety officer interviewed described the role of the health and safety committee. There is a current hazard register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Ryman Julia Wallace collects monthly incident and accident data and completes electronic recording of events on the VCare system. Monthly analysis of incidents by type is undertaken by the service and is reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Quality improvement plans have been created when the number of incidents exceeded the benchmark. Twelve accident incident forms reviewed (four rest home, five hospital and three dementia) identified timely RN assessment and that post falls assessments have been completed where required. Quality improvement plans were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 incident notifications since the last audit.</p>
Standard 1.2.7: Human Resource	FA	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the eight staff files (one clinical manager, two RNs, one EN, two</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>care assistants, one cook and one activities coordinator) reviewed. Performance appraisals are current in all files reviewed. Interviews with care assistants inform that management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained.</p> <p>There is an annual training plan aligned with the TeamRyman programme that is being implemented. Staff 'catch up' folders contain education content for staff to read and sign if they were unable to attend training. There is an aged care education coordinator/RN to support staff working towards the national standards. Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings and external education. Six of seventeen RNs (including the clinical manager) have completed their InterRAI training.</p> <p>Twelve out of eighteen care assistants who are employed in the dementia care unit have completed their dementia specific units. Six care assistants are progressing to complete their dementia specific units. Completion of induction programme and required dementia standards are required to be monitored and reported monthly to head office as part of the TeamRyman programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is at least one RN and first aid trained member of staff on every shift. Caregiver's advised that RNs (including coordinators) are supportive and approachable and stated that there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are sufficient staff to meet resident needs. There is access to both casual staff and part-time staff to cover unexpected absence. The care assistants cover a mix of long and short shifts. There is a serviced apartment coordinator (EN) from 8.00am-4.30pm, two care assistants in the morning (various times), two care assistants in the afternoon (various times). The RN in the hospital provides 24-hour clinical oversight for the rest home residents in the serviced apartments.</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</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with ministry of health medication requirements. Medication reconciliation of monthly blister packs is completed by RNs and any errors fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for medication competency on an annual basis (February 2016). Registered nurses, enrolled nurse and senior care assistants interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely in the four areas (rest home, serviced apartments, hospital and dementia care unit). Medication fridges were monitored weekly. All eye drops were dated on opening.</p> <p>There were three self-medicating residents (two rest home and one hospital) who had been assessed by the GP</p>

<p>safe practice guidelines.</p>		<p>and RN as competent to self-administer.</p> <p>Twelve medication charts (four hospital, four rest home and four dementia care) medication charts were reviewed on the electronic medication system. The effectiveness of 'as required' medications was entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food and baking is prepared and cooked on-site. The head cook is supported by a cook assistant and kitchen assistants. Staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with the dietitian at organisational level. Meals are delivered in hot boxes and served from bain-maries in the kitchenettes.</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 were available and offered for dislikes. Cultural, religious and food allergies are accommodated. Special diets such gluten free, vegetarian and 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 in fridges, freezers and in the pantry. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the cook.</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>PA Low</p>	<p>Residents interviewed reported their needs were being met and family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans are updated to reflect the changes in resident needs/supports however, not all interventions have been implemented. The previous shortfall around interventions remains. Short term care plans are developed for infections.</p> <p>Wound assessments, treatment plans and evaluations have been recorded (on the VCare system) for nine residents (rest home/hospital) with wounds (skin tears, lesions and two chronic ulcers). On the day of audit there were two stage two pressure injuries (one hospital acquired and one facility acquired) and one stage one pressure injury (facility acquired). There were six residents in the dementia care unit with wounds including skin tears, one surgical wound and lesions. The service has an RN/wound champion who reviews all chronic and non-healing wounds monthly and on request. Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse or district nurses as required. Chronic wounds and pressure injuries are</p>

		<p>linked to the long-term care plans.</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>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>	CI	<p>There is a team of seven activities persons (including three qualified diversional therapists – DT) to coordinate and implement the Engage programme across the four areas; rest home (Monday to Friday), hospital and dementia care unit (seven days a week) and serviced apartments (Monday to Friday). Activity staff attend on-site and organisational in-service relevant to their roles.</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 (twice daily in the dementia care unit and daily in other areas), themes events and celebrations, indoor bowls, baking, pet therapy, outings and drives. A mobility van is hired for hospital residents. Residents in the dementia care unit are taken for daily walks around the gardens and grounds as weather permits. Rest home residents in the serviced apartments attend the serviced apartment or rest home programme. Daily contact is made with residents who choose not to be involved in the activity programme. An activity assistant is allocated one-on-one time with hospital residents. Residents in the rest home have begun scrapbooking their own personal diaries. Community involvement includes entertainers, guest speakers, Duke of Edinburgh students, high school students, townhouse volunteers and Japanese college students. Five church services are held monthly in the on-site chapel.</p> <p>The service has been successful in engaging residents in the dementia care unit to develop their own memory boards and memory boxes. The service has maintained a continuous improvement in this area.</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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>Long-term care plans had been evaluated by registered nurses for long term residents who had been at the service six months. Written evaluations for long term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, care assistant, activities staff and other allied health professionals involved in the care of the resident. 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>

timely manner.		
<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>	FA	<p>The building has a current building warrant of fitness that expires 9 December 2016. Environmental improvements include the re-painting of all bedroom doors and relocating the cinema from the serviced apartment lounge area to the first floor which has created more space for activities and entertainment.</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>	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections, and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (registered nurse) completes a monthly report. Monthly data are reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. There is close liaison with the GP 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. Organisational benchmarking occurs.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. There were five residents voluntarily using six enablers (five bedrails and one chair brief) and four residents with five restraints (two bedrails and three chair briefs). Restraint and challenging behaviour education is included in the training programme.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Monitoring forms in place include (but not limited to) monthly weight, blood pressure and pulse, neurological observations post-unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes and long-term care plans document changes in health, however monitoring forms have been utilised to record changes for two rest home and two hospital resident files reviewed.</p>	<p>Interventions had not been implemented as follows; 1) Weekly weight for one dementia care resident with weight loss had not been completed as documented in the care plan. The same resident did not have episodes of challenging behaviour documented on the behaviour chart. 2) One dementia care resident had no pain assessment for a new pain as identified in progress notes.</p>	<p>1) and 2) Ensure interventions are implemented for changes in health status.</p> <p>60 days</p>

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
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Robust systems are in place for the collection, analysis and evaluations of quality data. Results are communicated to staff via a variety of forums. A range of data is collected across the service using VCare, an electronic data system. Data is collated and analysed with comprehensive evaluation reports completed monthly and comparative reports six monthly. The analysis of data gathered is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other similar service types within Ryman facilities. Communication of results occurs across a range of meetings across the facility (eg, management meetings, full facility meetings, clinical meetings). Templates for all meetings document action required, timeframe and the status of the actions. The quality programme for 2016 includes objectives for improving outcomes for residents. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is collected around (but not limited to) falls, skin tears, pressure injuries and infections.	Falls were identified as an area that required improvement from data collected from June 2016. A plan was developed as part of their 2016 quality goals which included identifying residents at risk of falling, providing falls prevention training for staff, reviewing call bell response times, reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the activities programme and reviewing of clinical indicator data. Further initiatives implemented included routine checks of all residents specific to each resident's needs (intentional rounding), the use of sensor mats, night lights, proactive and early GP involvement and increased staff awareness of residents who are at risk of

			<p>falling. The plan has been reviewed monthly and discussed at staff meetings. Education and training for staff has been regularly provided.</p> <p>Evaluation identified that falls have reduced during the period of June to October 2016. In the rest home, the rate of falls reduced from eight to three; in the hospital unit, the falls rate reduced from 18 to 12; and in the dementia unit, the rate of falls reduced from 36 to 19.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service identified that resident satisfaction and enjoyment could be increased for residents in the dementia care unit. The activity coordinator and staff identified residents often could not identify their room and could not get all residents involved in group activities.</p>	<p>An informal visit to the unit by a dementia care specialist recommended a bright and colourful unit with visual cues for residents with dementia. The activity coordinator has initiated meaningful activities that involved the relatives and residents.</p> <p>Improvements to the unit are as follows:</p> <p>1) The memory boxes on resident doors were re-decorated using the resident choice of colour, familiar photos and items that were easily recognisable by the resident. The result being, those residents can more easily find their rooms and become less confused.</p> <p>2) Each resident has a memory board with photos and collage that are special to the resident and their family. Residents assist in painting the boards in their colour choice and men apply the hooks and string to hang the boards that were displayed in 10 of the resident's rooms on the day of audit. Individual one-on-one time is spent with residents developing their boards, which have become a conversation and reminiscing</p>

			<p>activity.</p> <p>3) The activity coordinator changed the focus from large group activities to small cluster groups of activities ensuring “something for everyone” was being offered.</p> <p>The relative satisfaction survey results related to activities increased from a score of 3.17 in September 2015 to 4.03 in March 2016. This was an increase in 12 points among Ryman village rankings. The number of falls have reduced as a result of residents being able to identify their rooms and more residents engaging in smaller group activities (link C1 1.2.3.6).</p>
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End of the report.