

# Yvette Williams Retirement Village Limited

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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>	Yvette Williams Retirement Village Limited
<b>Premises audited:</b>	Yvette Williams Retirement Village
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 December 2016    End date: 15 December 2016
<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>	92

# 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

Ryman Yvette Williams provides rest home, hospital (medical and geriatric) and psychogeriatric level care for up to 122 residents. On the day of the audit there were 92 residents.

The service is managed by a village manager with support by a clinical 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.

One area for improvement has been identified around caregiver training in the psychogeriatric unit.

Areas of continuous improvement have been awarded for the activities programme and the reduction of the number of residents' 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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There is evidence that residents and family are kept informed. 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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvement are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided 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 nurses complete InterRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans are updated for changes in health status. The general practitioners complete an admission visit and review the residents at least three monthly.

The activity team provides an activities programme in each unit that meets the abilities and recreational needs of the groups of residents. Residents are encouraged to maintain community links. There are activity plans for residents in the psychogeriatric care unit that are individualised for their needs.

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

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Nutritional snacks are available 24 hours for residents in the psychogeriatric care unit. Residents interviewed responded favourably to the food provided.

## 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 posted in a visible location.

## 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. There were fourteen residents with restraint and one resident with an enabler. Staff have received education and training in restraint minimisation.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six monthly comparative summary is completed. Surveillance data is used to determine infection control activities and education needs at the facility.

## 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	15	0	1	0	0	0
<b>Criteria</b>	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)
<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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Interviews with all ten residents (three rest home including one in a serviced apartment, and seven hospital) and family confirmed their understanding of the complaints process. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner (HDC) Advocacy Service if resolution is not to their satisfaction.</p> <p>Interviews with two managers (village manager, clinical manager) and 16 staff (eight caregivers [two psychogeriatric, four hospital/rest home and two service apartments] who work across the am and pm shifts; four registered nurses (RNs), one enrolled nurse (EN), one diversional therapist, one activities coordinator, one cook) confirmed their understanding around the complaints process.</p> <p>There is a complaints register that includes written and verbal complaints, dates and actions taken. Six complaints were received in 2016 (year to date). All six complaints were managed in an appropriate and timely manner and were signed off as resolved. The complaints process is linked to the quality and risk management system.</p>
Standard 1.1.9:	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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 are not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>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 and in the residents' progress notes. All eight family interviewed (two psychogeriatric and six hospital) stated they were well-informed. Ten incident/accident forms and corresponding residents' files were reviewed and all identified that either the next of kin were contacted or requested not to be contacted (minor events only). Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Interpreter services are available if needed for residents who are unable to speak or understand English. Family are used in the first instance. A boarding school, adjacent to the facility also provides assistance with interpreter services with examples provided.</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>	FA	<p>Yvette Williams is a Ryman healthcare retirement village located in Dunedin. The care centre provides rest home and hospital care (geriatric and medical) for up to 60 residents and psychogeriatric care for up to 30 residents. There are also 32 serviced apartments certified to provide rest home level care with three rest home level residents occupying serviced apartments at the time of the audit. During the audit there were 89 residents in the care centre (4 rest home, 55 hospital and 30 psychogeriatric). One rest home level resident in the care facility was on respite.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2016 are defined with evidence of regular reviews.</p> <p>The village manager has been employed by Ryman for over three years. She has attended over eight hours per annum of professional development activities related to managing an aged care facility. The village manager is supported by a full time clinical manager/RN and a regional manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	FA	<p>Yvette Williams 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. Discussions with the management team and staff, and review of management and staff meeting minutes reflect their involvement in quality and risk activities.</p> <p>Family meetings are held six monthly and residents meetings are held every two months. Minutes are</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level. 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. There are clear guidelines and templates for reporting. Management systems, policies, and procedures are developed, implemented and regularly reviewed.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Corrective actions are implemented and signed off where internal audit results reflect less than 95% compliance. In addition, quality improvement projects (QIPs) are implemented where opportunities for improvement are identified with several examples provided. QIPs are signed off by the village manager when completed. A previous rating of continuous improvement around the low number of resident falls remains.</p> <p>Health and safety policies are implemented and monitored via the two monthly health and safety meetings. A health and safety officer is appointed who has completed external stage one health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC workplace safety management practice (expiry 31 March 2017). The hazard register indicates that identified hazards are regularly reviewed.</p> <p>Falls prevention strategies are in place. Lounge carers monitor residents in the lounges. The falls rate for residents remains low.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded</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>Ten incident/accident forms reviewed identified that all are fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the applicable meetings (eg, team Ryman, RN, care staff, health and safety/infection control). This provides the opportunity to review any</p>

<p>by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>incidents as they occur.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities with examples provided.</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>PA Low</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (four caregivers, one registered nurse, one cook and one kitchen hand) provided evidence of the employment process including interviewing, police vetting and reference checks. Also sighted in all seven files were signed employment contracts, job descriptions, completed orientation programmes and annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates are maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. A small number of caregiver staff employed in the psychogeriatric unit for over one year have not completed their dementia qualification.</p> <p>RNs are supported to maintain their professional competency. Eight of twenty-one RNs have completed their InterRAI training. Staff training records are maintained. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies.</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>In addition to a full time clinical manager/RN, there are three unit coordinators, one for each area/floor. An enrolled nurse (EN) is the unit coordinator for the 32 serviced apartments with three rest home level residents on the third floor. One RN unit coordinator is responsible for the fifty-five hospital level residents and four rest home level on the second floor, and one RN unit coordinator is responsible for the 30 psychogeriatric residents on the first level.</p> <p>All three units are staffed with suitable numbers of RNs with a minimum of two RNs (one hospital, one psychogeriatric) and five caregivers on site during the night shift. The serviced apartments are staffed with a unit</p>

		<p>coordinator five days a week and one caregiver for the am and pm shifts. The hospital level caregivers are responsible for the serviced apartments during the night shift. All staff wear pagers.</p> <p>Activities are provided seven days a week for all residents in the care centre. A registered physiotherapist is available three days a week totalling fifteen hours. There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were 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 reported 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. Medicine management complies with Ministry of Health medication requirements. An RN and pharmacist complete medication verification on delivery and an RN completes reconciliation. Qualified nurses and care staff interviewed were able to describe their role about medicine administration. Medications were stored safely and medication fridges were monitored weekly. Eye drops are dated on opening.</p> <p>Standing orders are not used and no residents self-administer. Twelve medication charts were reviewed. The medication charts and signing charts (including for the respite resident) met legislative requirements.</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>The service employs five cooks who are supported by four kitchen assistants. All cooks and two kitchenhands have been trained in food safety and chemical safety. Two of the kitchenhands had just commenced and were to undertake their training. A four weekly seasonal menu has been designed in consultation with company chefs and the dietitian at organisational level. A dietitian is also available locally for information. All meals are prepared and cooked on-site.</p> <p>The cook (interviewed) receives a resident dietary profile for all new admissions and is notified of any dietary changes such as residents with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft, diabetic desserts and gluten free are provided. Food is delivered in four bain-maries and served in the unit kitchenettes. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded daily. Serving temperatures are taken and chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits. Nutritious snacks are delivered to the special care unit (psychogeriatric unit) daily and as requested.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed also 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 review. Care plans are updated to reflect the resident's current health status. Care plans reviewed in the resident files sampled reflected the resident's current supports and needs.</p> <p>Wound assessments and ongoing evaluations were in place on the VCare system for all current wounds (six skin tears, one blister and three lesions) and three pressure injuries (facility acquired). Adequate dressing supplies were sighted in the treatment rooms. Wound care advice and support can be readily sought from the DHB wound specialist nurse.</p> <p>Contenance products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts.</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>	<p>FA</p>	<p>Activity coordinators implement separate activities in two lounges for rest home and hospital unit residents to choose between. In the psychogeriatric unit an activity coordinator (qualified diversional therapist) leads the programme and is assisted by activity coordinators on the weekend and 'lounge carers' from 4pm to 8pm daily.</p> <p>The Ryman 'Triple A' (aware, active, ageless) programme is in place and guidance is received from head office.</p> <p>The programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Changes had been made to encourage greater participation and satisfaction with the activity programme and the upward trend over the previous six months indicated greater interest in the programme. Activities were observed being delivered simultaneously in the rest home/hospital lounges and psychogeriatric unit. Rest home residents in the serviced apartments may choose to attend activities in a number of areas. Daily contact is made and one-on-one time spent with residents who are unable to participate in group-activities or choose not to be involved in the activity programme. Residents in the psychogeriatric care unit were observed to be involved in facility activities under supervision. Supervised daily walks outside (weather permitting) or within the facility occurs.</p> <p>There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events and charities. Regular church services are held.</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</p>

		through the resident meetings and satisfaction surveys.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses' six monthly or when changes to care occurred. Written evaluations describe the residents' progress against the residents' (as appropriate) identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family. Family are notified of the review and if unable to attend may submit queries and 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 are invited to attend the multidisciplinary care plan reviews and GP visits.</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>	FA	<p>A current building warrant of fitness is posted in a visible location (expiry 14 October 2017).</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 describes the purpose and methodology for the surveillance of infections. Definitions of infections are in place and appropriate to the complexity of the service provided. Individual infection reports are electronically recorded and a checklist for care is generated. The infection control officer (interviewed) collects monthly data and attends the two monthly health and safety meetings. Staff are informed through facility meetings held at the facility. The infection prevention and control programme is linked with the team Ryman programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback to the service. Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were fourteen residents with restraint (seven hospital and seven psychogeriatric) and one hospital level resident voluntarily using enablers (bedrails and lap belt). An</p>

is actively minimised.		appropriate assessment and written consent was completed for the use of the enablers. Staff training is regularly provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>An education schedule is being implemented. Training is specific to job roles and includes both internal and external training.</p> <p>Twenty-four caregivers work on a regular basis in the psychogeriatric unit. Fifteen have completed their dementia qualification and nine caregivers are enrolled. Four of the nine have been working on a regular basis in the psychogeriatric unit for over one year and have yet to complete their dementia qualification.</p>	<p>Four caregivers who have worked in the psychogeriatric unit for over one year on a regular basis have not completed their dementia qualification.</p>	<p>Ensure that all caregiver staff complete their dementia qualification within their first year of working in the psychogeriatric unit.</p> <p>90 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	Systems are in place for the collection, analyses, and evaluation of quality data. Data analysis identifies normal variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings. Templates for meetings document actions required, timeframes, and the status of the actions.	Strategies implemented to reduce the number of falls include providing falls prevention training for staff, encouraging resident participation in the activities programme, and reviewing of clinical indicator data. A lounge carer is assigned between 4pm and 8pm, delivering a modified activities programme whilst supervising residents who are in the lounge during this time. Other falls initiatives implemented include routine checks of all residents specific to each resident's needs (intentional rounding), the use of sensor mats, perimeter mats, night lights, proactive and early GP involvement, and increased staff awareness of residents who are at risk of falling. Caregivers interviewed were knowledgeable in regards to preventing falls and those residents who were at risk. The falls management strategy is regularly reviewed and discussed at staff meetings. Both the hospital and psychogeriatric units have exceeded the Ryman standard in staying beneath 11/1000 bed nights and are ranked 7th overall (out of 27 villages). This previous area of continuous improvement remains.

<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>A separate activity programme is provided for the rest home, hospital, special care unit and serviced apartments. The activities programme is provided for seven days a week in the facility by a combination of full time, part time and casual staff. Residents in the village apartments are involved in the activities programme. There are set calendar events and expectations for each area including the triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The 'Engage at Ryman' programme is being included in the programme and participation continues to increase since its commencement.</p>	<p>The change in timing, range and increase of activities offered to residents in the rest home (including rest home residents in apartments) and hospital has resulted in an increase of 20% attendance of residents attending activities. The raw data does not factor in that there was a 10% decrease in occupancy in this period so attendance per resident would on average be higher than the 20% referred to indicating a greater level of satisfaction and interest. In the special care (psychogeriatric) unit there was a recorded increase of attendance of 22%. There were additional activities offered in the lounge between 4pm and 8pm also, however attendance at these is not recorded.</p>
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End of the report.