

Bob Owens Retirement Village Limited - Bob Owens Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bob Owens Retirement Village Limited
Premises audited:	Bob Owens 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: 11 October 2017 End date: 12 October 2017
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:	118



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

Bob Owens is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital (geriatric and medical) and dementia level care for up to 150 residents. On the days of the audit there were 118 residents including seven residents receiving rest home level of care in serviced apartments.

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, relatives, general practitioner, management and staff.

An experienced non-clinical village manager manages the service. He is supported by an experienced clinical manager and assistant manager. The residents and relatives interviewed spoke positively about the care and support provided.

The service has addressed the one previous audit finding around general practitioner medication reviews. This surveillance audit identified one shortfall around nursing reviews.

An area of continuous improvement was identified around falls reduction.

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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Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

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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Bob Owens continues to implement the TeamRyman programme that provides the framework for quality and risk management and the provision of clinical care. The service has policies and procedures to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Key components of the quality and risk management system include monitoring all adverse events. Data is collected, analysed and evaluated. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. An annual education schedule is in place for 2017. In addition, opportunistic education is provided. Aged care education is in place for the caregivers. There is adequate staff at the facility. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The registered nurse's complete assessments, care plan development and evaluations within the required timeframe. Monitoring forms were being utilised. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status.

The activity team provides an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community. There were 24-hour activity plans for residents in the dementia care unit that were 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 competencies and education. Medication is appropriately stored, managed, administered and documented.

All meals are prepared on-site. A dietitian designs the menu at an organisational level. Individual and special dietary needs are catered for. Nutritional snacks are available 24-hours for residents in the dementia 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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The building holds 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 were policies and procedures that meet the restraint standards. The clinical manager is the restraint coordinator. The use of enablers/restraint is discussed at clinical meetings and TeamRyman meetings. Challenging behaviour and restraint minimisation and safe practice education has been provided. There were two residents requiring enablers and one resident with a restraint at the time of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control team hold integrated meetings with the health and safety team. Monthly infection events are collated and forwarded to head office for analysis and organisational benchmarking. The results of surveillance are used to identify infection control quality initiatives and education requirements. There have been no outbreaks within the last year.

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	0	15	0	1	0	0	0
Criteria	1	37	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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. Three complaints were made in 2016 and one complaint reviewed for 2017 (year-to-date) have been managed in a timely manner and are documented as resolved. The regional manager reported that all complainants are contacted by Ryman Christchurch to ensure that their complaint is resolved. If the complaint is not resolved, the regional manager becomes involved. The complaints process is linked to the quality and risk management system.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Ten residents (four hospital and six rest home) 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 around their responsibility to notify family of any resident accident/incident that occurs. Twelve incident/accident forms and corresponding residents' files were reviewed, and all identified that next of kin were contacted. Two relatives (hospital) stated that they have been informed when their family members health status changes. Bi-monthly resident and family meetings provide a forum for residents to discuss issues or concerns. An interpreter policy and contact details of interpreters are available. The information pack is available in large print</p>

environment conducive to effective communication.		and this can be read to residents.
<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>Bob Owens is a Ryman Healthcare Retirement Village located in Tauranga. The facility is built across three floors and is designed around a large atrium and courtyards and provides rest home, hospital (geriatric and medical) and dementia level care for up to 150 residents. This includes 30 serviced apartments certified to be able to provide rest home level care, 40 rest home level beds, 40 hospital level beds and 40 dementia care level beds. Occupancy during the audit was 118 residents in total, 44 rest home level residents (including four in the serviced apartments), 39 hospital level residents and 35 dementia level residents across two 20-bed secure units. All residents were on the aged related residential care (ARRC) contract.</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 2017 are defined with evidence of regular reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been in the role since April 2015 and has previous experience managing legislative and assurance audits for the district health board. He is supported by an experienced clinical manager who oversees clinical care and has been in the position for two years, and an assistant manager who carries out administrative functions. The village manager was absent at the time of the audit. The wider Ryman management team includes a regional manager who supports the management team. The regional manager was present during the audit.</p> <p>The village manager and clinical manager have maintained at least eight hours of professional development activities related to managing a retirement village.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	FA	<p>Ryman facilities have 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 managers and staff; and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. 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>Key components of the quality management system include (but are not limited to) monitoring falls, medication errors, restraint use, pressure injuries, infections, wounds and resident satisfaction. Monthly reports by the village manager to the regional manager provide a coordinated process between service level and the organisation. Regular meetings are held throughout the service. There are monthly accident/incident reports that break down the data collected across the rest home, hospital, dementia unit and staff incidents/accidents. Falls prevention</p>

<p>principles.</p>		<p>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 internal audit programme monitors key components of the service. If a target is not met or an area of non-compliance is identified a quality improvement plan (QIP) is developed and implemented.</p> <p>Health and safety policies are implemented and monitored. A senior caregiver is the health and safety officer and is supported by health and safety representatives. Health and safety meetings are conducted two-monthly. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice (expiry 31 March 2018).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual incident reports are documented electronically for each incident/accident. Significant events were documented in the residents' progress notes. The data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Twelve incident forms were reviewed; all reviewed reflected timely clinical assessment and follow-up by a registered nurse (RN)- link 1.3.3.4. Accident/incident forms reviewed had documented corrective actions taken and any follow-up action required. Discussions with the regional manager and clinical manager confirm their awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification for a stage three pressure injury in September 2017 was reported.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>The organisation provides documented job descriptions for all positions, which detail each position's responsibilities, accountabilities and authorities. Relevant documentation was seen in eleven staff files reviewed (one clinical manager, two unit-coordinators, two RNs, four caregivers, one activities coordinator and one head chef) included a signed contract, job description relevant to the role of the staff member, evidence of completed orientation programmes (general and specific to the position), application form and reference checks. Eight-week performance reviews are completed following employment and are scheduled annually thereafter. A register of RN and EN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>for safe work practice. It is tailored specifically to each position.</p> <p>There is an annual education plan in place for 2017. Staff training records are maintained. The annual training programme is scheduled to exceed eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Training requirements are directed by Ryman Christchurch and are reviewed as part of the TeamRyman reporting. Nursing staff are supported to maintain their professional competency. Seven of sixteen RNs have completed their interRAI training. There are implemented competencies for nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies. Nineteen of twenty-two caregivers who work in the dementia unit have completed their dementia qualification and the remaining three are enrolled and working on completing their qualification.</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>Ryman policy supports the requirements of skill mix, staffing ratios and rostering. There is a RN and first aid trained member of staff on every shift. Caregiver's interviewed stated that management are supportive and approachable. Staff interviewed advised that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm that there are sufficient staff on duty. The village manager and clinical manager both work 40 hours per week. The facility is on three levels; rest home residents are on the first floor, hospital level care residents are on the second floor and dementia level care residents are on the third level.</p> <p>There are 30 serviced apartments certified to provide rest home level of care. Four rest home level residents were living in serviced apartments at the time of the audit. The serviced apartment unit coordinator is an enrolled nurse (EN) and works Sunday to Thursday. The morning shift is staffed by the unit coordinator or a senior caregiver with one caregiver from 7.00am to 3.00pm, the afternoon shift is staffed by one caregiver from 3.00pm to 9.00pm. The remaining times are covered by the caregivers caring for rest home level residents. Staff communicate via mobile telecommunications.</p> <p>Forty of forty rest home residents were living on the first floor. A unit coordinator/RN is rostered five days a week. One RN is on duty in the morning shift. The RN in the hospital provides oversight for the afternoon and night shifts. Four caregivers (two long and two short shift) are on duty in the morning shift and in the afternoon shift, and two caregivers are on duty for the night shift.</p> <p>Thirty-nine of forty hospital level residents were living on the second floor. A unit coordinator/RN is rostered five days a week. Two RNs are on duty in the morning and afternoon shifts and one RN is on duty in the night shift. Eight caregivers (four long and four short shift) are on duty in the morning shift, six caregivers (three long and three short shift) are on duty in the afternoon shift and three caregivers are on duty for the night shift.</p> <p>On the third floor there are two secure 20-bed dementia units with a shared office between. There was a total of 35 residents (17 residents in one unit and 18 residents in the other unit). A unit coordinator/RN oversees both units Seven days a week during day shift. The RN in the hospital provides oversight for the afternoon and night shifts. There are four caregivers across the two units (one long and one short shift in each unit) are on duty in the morning</p>

		shift and in the afternoon shift, and three caregivers are on duty for the night shift across the two units.
<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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication is stored and administered in accordance with current legislation and guidelines. Bob Owens uses an electronic medication management system. All medication fridges are temperature checked weekly and corrective actions documented where temperatures are outside the required range. On delivery of medication, an RN completes medication reconciliation and any errors fed back to pharmacy. 'As required' (PRN) medication expiry dates are checked monthly. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided.</p> <p>Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Standing orders are not used. There is currently one resident self-administering one of his medications. The resident's competency is checked three monthly and a record signed by the GP is kept on file. This partial finding from the previous audit has been addressed. Fourteen medication charts and signing sheets were reviewed (six rest home [including two from the serviced apartments] and four hospital and four dementia care). Photo identification and allergy status were on all charts. All medication charts for long-term residents had been reviewed by the GP at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service employs a qualified head chef who is supported during day shifts by a second chef and kitchenhands. An afternoon chef, a cook's assistant and kitchenhands support afternoon shifts. All staff have been trained in food safety and chemical safety. A four-weekly seasonal menu had been designed and reviewed by a dietitian, at organisational level. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes following the six-monthly reviews and at other times, such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes, food allergies and dietary preferences were known. Alternative foods are offered including two menu options for all lunch meals. Special diets such as pureed/soft meals, diabetic desserts, and gluten free are provided.</p> <p>Nutritious snacks including (but not limited to) sandwiches, yoghurt and snack-sized meals are available 24 hours. Food is delivered in hot boxes to each area and served from bain maries. Residents with special meal requirements have their meals plated by care staff who maintain a list of resident requirements. The serving temperature in the bain maries are monitored and recorded daily. Fridge and freezer temperatures are checked twice daily. Chilled goods temperature is checked on delivery. Food temperatures are monitored twice daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident and staff meetings, surveys and audits. The head chef has regular contact with residents and receives feedback on the meals. Residents and relatives interviewed spoke positively about the food service.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the RN initiates a review and if required a GP visit (link 1.3.3.4). Communication with the GPs for residents' change in health status was sighted in the resident's files. Wound assessments, treatment and evaluations were in place for all current wounds, (13 skin tears, two chronic ulcers, one surgical, eight pressure injuries, and 10 other minor wounds). There were seven current pressure injuries in the hospital wing including six with grade two pressure injuries (four of which were facility acquired) and one resident with a grade one pressure injury (facility acquired). There was one resident in the rest home with a facility acquired grade one pressure injury.</p> <p>Pressure area prevention strategies are included in the long-term care plans for all residents identified as high risk of pressure injury. Pressure injury prevention interventions include (but are not limited to), two to four hourly repositioning and skin care, the use of pressure reducing mattresses and cushions and heel protectors. General practitioners are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management from the Ryman wound care nurse specialist. Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Monitoring forms in place include (but are not limited to) weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts as needed.</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>The activity team consisting of two qualified diversional therapists and three activities coordinators (two are in the process of completing their diversional therapy training). The two activity coordinators in the dementia units are qualified caregivers with the dementia units. The team implement a separate activity programme for the rest home, hospital and dementia areas. The Ryman 'Engage' programme is delivered Monday to Friday in the rest home and hospital and seven days a week in the dementia care unit. The 'Engage' programme provides activities that are meaningful and relevant for all cognitive capacities and are gender appropriate.</p> <p>Some of the activities such as entertainment and church services are integrated for all residents. One-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There are regular outings/drives for all residents (as appropriate) and involvement in community groups including floral society, conservation projects, library, canine friends and charities. The resident or family/whānau as appropriate, complete a life experience form on admission and are involved in the development of the activity plan. A record is kept of individual resident's activities. Files reviewed included an individualised activity plan that had been evaluated at least six monthly with the care plan review. Activity plans for residents in the dementia unit included activities across 24/7 and de-escalation techniques when needed. Resident meetings are</p>

		held bi-monthly and are open to families to attend.
<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 RNs six monthly or when changes to care occurred. Care plans for short-term needs are used for infection events and are evaluated and signed off when resolved. The MDT review involves the RN, GP, activities staff, resident/family and other health professionals involved in the resident's care. The family are notified of the outcome of the review by phone and if unable to attend receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the MDT 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>The building holds a current warrant of fitness which expires on 12 August 2018. A preventative and reactive maintenance programme is in place.</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 appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and kept as part of the resident files. Infections were included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff were informed through the variety of meetings held at the facility. The infection prevention and control programme is linked with the TeamRyman 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/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks within the last year.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	FA	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. There was one hospital resident using a restraint (bed rail) and two hospital residents with enablers (lap belts) on the day of audit. Two resident files reviewed</p>

Services demonstrate that the use of restraint is actively minimised.		demonstrated that enabler use is voluntary. The clinical manager is the restraint coordinator. The use of enablers/restraint is discussed at clinical meetings and TeamRyman meetings. Challenging behaviour and restraint minimisation and safe practice education has been provided.
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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 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	RNs entries and review of identified issues in progress notes were evident in six of the seven files sampled. The sample was expanded by two rest home level care residents in the apartments around RN/EN follow-up. In all three files sampled, there was inconsistent RN/EN follow-up when the resident was unwell or had an event such as a fall. RNs or ENs are responsible for reviewing and completing regular assessments.	In three files sampled for rest home level residents in the serviced apartments there was insufficient evidence of RN/EN review following changes in health or an adverse event.	<p>Ensure all residents evidence review following adverse events or a change in health.</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
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>There is a quality and risk management process in place. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. All meetings include feedback on quality data where opportunities for improvement are identified.</p> <p>Bob Owens is proactive in developing and implementing quality initiatives. Quality improvement plans (QIP) are developed where results do not meet expectations. There is a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch.</p>	<p>Bob Owens is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data, the village manager and clinical manager discuss the data at the monthly staff meetings and any identified trends or issues. Any identified common themes around incidents/infections etc. results in further education and toolbox sessions. Bob Owens implemented a falls prevention and management QIP in September 2016, which focused on identifying strategies for the reduction of dementia resident falls.</p> <p>Strategies included, improved physiotherapy input into care of dementia residents to develop transfer plans, maintain mobility of residents and post fall reviews to identify mobility issues or other factors contributing to falls, continued falls prevention education for all staff and falls data analysis discussed weekly and available for all staff to view.</p>

		<p>The system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.</p>	<p>Documentation reviewed identified that strategies were regularly evaluated. The outcome achieved is that the total of dementia resident falls has reduced from a rate (per 1000 occupied bed days) of 30.01 falls for September 2016 down to 12.11 falls in August 2017.</p>
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End of the report.