

Ryman Healthcare Limited - Woodcote

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:	Ryman Healthcare Limited
Premises audited:	Woodcote Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 October 2017 End date: 10 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:	46

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

Woodcote Retirement Village is a Ryman Healthcare facility which provides rest home level care across a 49-bed rest home and seven serviced apartments. On the day of audit there were 46 residents including one rest home resident in the serviced apartments.

This 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, management, staff and a general practitioner. The residents and relatives interviewed spoke positively about the care and support provided.

The village manager is a registered nurse and is experienced in village management, having been in the role for six years. She is supported by two registered nurses (one as clinical manager/deputy village manager).

The service continues to make improvements to services and has a number of quality initiatives being implemented. A continued improvement rating continues to be awarded around implementation of the quality system.

This audit identified an improvement required around medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

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.		Standards applicable to this service fully attained.
---	--	--

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 continues to be implemented. Corrective actions are implemented and evaluated where opportunities for improvements 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. A comprehensive orientation programme is in place for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided eight hours a day, seven days a week with an on-call RN available out of these hours. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Registered nurses are responsible for all stages in the provision of care including interRAI assessments, risk assessments, development of care plans and evaluations. Resident files demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review and were informed of any changes in resident health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

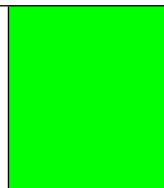
The activity team provides an activities programme, which is varied and interesting. Residents are encouraged to maintain links with community groups.

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 all units.

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.

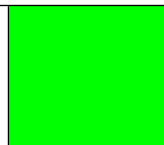


Standards applicable to this service fully attained.

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.

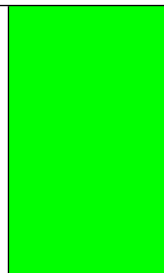


Standards applicable to this service fully attained.

Ryman Woodcote has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using a restraint or an enabler. The service has remained restraint-free for five years.

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.

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	0	1	0	0
Criteria	1	39	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints' register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner and timeframes are met. Since March 2016 through to Oct 2017, there have been seven complaints. There had been nil H&D complaints. Complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff report all incidents and accidents to the registered nurses who enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>

<p>provide an environment conducive to effective communication.</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>Ryman Woodcote is certified to provide rest home level care. The 49-bed rest home area is part of the wider retirement village which includes seven serviced apartments and villas. The serviced apartment area is also certified for rest home level care. On the day of audit there was one rest home resident in the service apartments and 45 rest home residents in the care centre (including three respite residents).</p> <p>There were no residents on the day of audit admitted under other contracts.</p> <p>Ryman Healthcare has an organisational total quality management plan in place. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the Team Ryman Programme.</p> <p>The village manager (clinical) commenced employment in 2011. She is supported by a clinical manager who has been in the role since 2012. The village manager, in consultation with the clinical manager, leads the daily operation of the village and shares RN on-call cover. The serviced apartments are staffed with an apartment coordinator, seven days a week from 7.00am to 1.30pm. Out of these hours they are serviced by rest home staff.</p> <p>The management team is supported by the wider Ryman management team, which includes support from a regional manager.</p> <p>The village manager and clinical manager have maintained at least eight hours to date of professional development activities related to managing a 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>	<p>FA</p>	<p>Woodcote has a well-established quality and risk management system that is directed by head office. Quality and risk performance is reported across the facility meetings and also to the organisation's management team. Discussions with the managers (village manager/RN and clinical manager/RN), the GP and staff (four caregivers, two activity coordinators and registered nurse) and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.</p> <p>Resident meetings are held two-monthly. Relative meetings are held six-monthly. Minutes are maintained. Annual resident and relative surveys are completed annually. An annual resident satisfaction survey was completed in March 2017 and the results showed the overall resident experience in Woodcote rated second to highest in positive experience in the Ryman group. Action plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of</p>

<p>principles.</p>		<p>assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly Team Ryman process. They are communicated to staff as evidenced in staff meeting minutes.</p> <p>Team Ryman prescribes the annual internal audit schedule that was being adhered to. Audit summaries and quality improvement plans are completed where a non-compliance is identified. Issues and outcomes are reported to the appropriate committee (e.g., health and safety). Results are communicated to staff and reflect actions being implemented and signed off when completed.</p> <p>Monthly clinical indicator data are collated across all areas. There is evidence of trending of clinical data and development of quality improvement plans when results do not meet expectations. The quality system includes the monitoring of adverse events, consumer complaints, infection prevention and control, health and safety and restraint management. The combined health and safety and infection prevention and control committee meet bi-monthly and include discussion of all incidents/accidents and infections. There is a current hazard register in place. Management reports progress to head office staff at least monthly, against the quality and risk management plan and quality improvement initiatives.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>The service has implemented a number of quality initiatives since previous audit.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings that also include review of infection control and of incidents. 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. The hazard identification resolution plan is sent to head office and documents any key hazards that are identified. A review of the hazard register and the maintenance register indicates there is resolution of issues identified.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or</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. Ten accident and incident reports were reviewed.</p> <p>A review of incident/accident forms for the facility identifies that all are fully completed and include timely follow-up</p>

<p>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>by a registered nurse. The managers are involved in the adverse event process with regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify significant events that would be reported to statutory authorities. There have been three notifications this year. Two notifications relating to a resident's behaviour were made (the resident was reassessed and appropriately placed) and the third related to an intruder onsite.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files reviewed (two caregivers, one registered nurse, one activities staff, one chef and one clinical manager), included a signed contract, job description, police checks for those employed in recent years, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of registered nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. Two registered nurses (including the clinical manager) have completed their interRAI training, meeting contractual requirements. Staff competencies are completed as relevant to the role.</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</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. The clinical manager and registered nurse cover 8.00am to 4.30pm each day of the week and the village manager and clinical manager share on-call. The staff on at night do not leave the building to attend village residents.</p> <p>There are four caregivers on morning and afternoon duty with two on night duty. The serviced apartments are staffed separately seven days a week from 7.30am to 1.30pm with the rest home staff providing services out of these hours.</p> <p>On the day of the audit, staff were visible and attending to call bells in a timely manner as confirmed by residents</p>

service providers.		interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.
<p>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>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation of monthly blister packs is completed by two RNs and any errors fed back to the pharmacy. Medications were stored safely in a central medication room. Medication fridges were monitored weekly. All eye drops and creams in medication trolleys were dated on opening. Weekly stocktakes of controlled drug medication were not completed as per policy. Registered nurses and senior care assistants who administer medications have been assessed for competency. Appropriate medications were signed by two medication competent staff, one of which was a RN. The service uses an electronic medication system. Care staff interviewed could describe their role in regard to medicine administration. Education around safe medication administration has been provided. The administration of medicines observed during the morning and lunchtime medication round did not fully comply with the medication administration policies and procedures.</p> <p>There are three rest home level residents self-medicating inhalers and one resident self-administering all medications. The inhalers are kept in a locked drawer in the resident rooms. RNs assess competency three-monthly. The competency is kept on file in the medication room.</p> <p>Ten medication charts were reviewed on the electronic medication system. All medications had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is 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>	FA	<p>All food and baking is prepared and cooked on-site. The qualified head chef is supported by a cook and kitchen assistants. Staff have been trained in food safety and chemical safety. Project "delicious" was commenced at the time the facility opened. Menus are completed one week in advance and offer a choice of one main dish for the midday meal and two choices for the evening meal including a vegetarian option. Resident dislikes are accommodated. Diabetic desserts and gluten free diets are accommodated. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Food is served directly from the kitchen to the adjoining dining room. Staff were observed sitting with the residents when assisting them with meals. The service is well-equipped. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. All foods were date labelled. A cleaning schedule is maintained. Positive feedback on the food service has been received from resident and staff meetings, surveys and audits. Residents interviewed all spoke positively about the food provided.</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. The 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 reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (e.g., resident turns, fluids given). Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved completes the short-term care plan.</p> <p>Wound assessments, treatment and evaluations were in place for three residents with five wounds. (These included three skin tears, one skin lesion and one surgical wound. Wound assessments and management plans are completed on VCare and updated automatically in myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule.</p> <p>Registered nurses interviewed could describe access to wound specialist nurses if required. The GP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. New wounds were recorded in the VCare systems.</p> <p>Continence products are available and resident files included 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>	<p>FA</p>	<p>The team of activities staff (one with diversional therapy qualifications and one activities coordinator) coordinate and implement the Engage activities programme across the rest home. A separate programme operates for serviced apartment residents who can choose which programme they would prefer to attend. The programme is Monday to Friday in the rest home and serviced apartments.</p> <p>Activities staff attend on-site and organisational in-services relevant to their roles. The activities staff hold current first aid certificates.</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 A exercises, themed events and celebrations, baking, sensory activities including pet visits, outings and drives. A facility van is available for outings for all residents. The rest home lounge areas have seating placed for large and smaller group activities. Woodcote provides pet therapy with a house cat and bird, and a dog who visits three times a week and takes part in resident's walks. Daily contact is made with residents who choose not to be involved in the activity programme.</p>

		<p>Community involvement includes entertainers, speakers, volunteers and visitors bringing in their pets weekly.</p> <p>There are opportunities for residents from both units to join together for larger celebrations, and to catch up with old friends if the resident has moved to the rest home from serviced apartments for example.</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 can feedback on the programme through the resident and relative meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans reviewed had been evaluated by registered nurses for long-term residents who had been at the service six months and longer. 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.</p> <p>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. Record of the MDT review was evident in the resident files reviewed. 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>
<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 1 June 2018).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. The infection prevention and control programme links with the quality programme. There is close</p>

<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>liaison with the GPs 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. An outbreak involving 42 staff and residents in July 2017 was managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service has been restraint-free since 2012. There were no enablers in use.</p> <p>The restraint coordinator (village manager who is an RN) maintains a register which is forwarded to Ryman each month. The use of enablers/restraint is discussed at six-monthly restraint meetings (April 2017). Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided. The caregivers interviewed were knowledgeable in the use of enablers/restraint.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The service has appropriate policies and procedures around medication management, storage and administration. Weekly stocktakes of controlled drugs were not always completed as per policy. All medications were stored appropriately. Administration procedures for administration of medications were not always followed.</p>	<p>i) There was evidence of gaps in the controlled drug register for three resident's records.</p> <p>ii) Staff were observed not following policy and procedure during administration.</p>	<p>i) Ensure that weekly stocktakes occur as per policy.</p> <p>ii) Ensure that medication administration policies and procedures are implemented by staff.</p>

				60 days
--	--	--	--	---------

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>A range of clinical indicator data are collected and reported through to Ryman Christchurch (head office) 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. Feedback is provided to staff via the various meetings as determined by the Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. 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>The service continues to implement a number of quality initiatives as a result of quality data collected and analysed.</p>	<p>The service has continued to implement quality initiatives as a result of quality data collected. One example was the monitoring of response times to call bells, strategies implemented as a result which is continually monitored and reviewed. Evaluation identifies a reduction in call bell wait times over the last six months and a corresponding reduction in falls rate was evidenced.</p>

End of the report.