

Malvina Major Retirement Village Limited

Introduction

This report records the results of a Certification 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:	Malvina Major Retirement Village Limited
Premises audited:	Malvina Major Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 August 2015 End date: 19 August 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	113

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

Malvina Major Village is a Ryman Healthcare facility. The facility provides rest home and hospital level of care for up to 120 residents. On the day of audit, there were 113 residents in the care centre and three rest home residents in the serviced apartments.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, general practitioner, management and staff.

The village manager is suitably qualified and supported by a clinical services manager (registered nurse) and an assistant village manager. There were structured systems in place to provide support and guide appropriate care for residents. Implementation of quality systems are being supported through the Ryman Accreditation Programme. An induction and in-service training programme is implemented to provide staff with appropriate knowledge and skills to deliver care.

This audit identified an improvement required around aspects of medicine management.

The service has been awarded a continuous improvement (CI) rating around good practice.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Malvina Major Village provides care in a way that focused on the individual residents' quality of life. There is a Māori Health Plan and implemented policy supporting practice. Cultural assessments are undertaken on admission and during the review process. Policies are being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents and families. Care plans accommodated the choices of residents and/or their family. Informed consent was sought and advanced directives were appropriately recorded. Complaint processes were being implemented and complaints and concerns were managed appropriately. Residents and family interviewed verified ongoing involvement with the community.

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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Malvina Major service is implementing the Ryman Accreditation Programme. Key components of the quality management system linked to a number of meetings including staff meetings. An annual resident/relative satisfaction survey has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. There are human resource policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provided new staff with relevant information for

safe work practice. There is an in-service training programme covering relevant aspects of care and support including external training. The organisational staffing policy aligned with contractual requirements and included skill mixes.

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>
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Residents and families receive a comprehensive admission package outlining the services available at Ryman Malvina Major. The service has a well-developed assessment process and residents' needs are assessed prior to entry. The registered nurses complete assessments, care plans and evaluations. Care plans are reviewed and updated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available and implemented, and used to the level of support required for residents. Residents/relatives are involved in planning and evaluating care. Care plans demonstrate service integration. The service facilitates access to other medical and non-medical services.

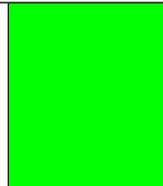
The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

Medication policies and procedures are in place to guide practice. All staff responsible for administration of medicines completed education and medication competencies. The medication charts reviewed include documentation of allergies and intolerances.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food that was 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.

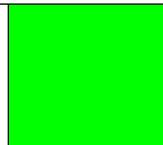


Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single and have ensuites. There is sufficient space to allow for the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. The service has an approved fire evacuation scheme. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Housekeeping staff maintain a clean and tidy environment. All laundry and linen was completed on-site.

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.

There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager/restraint officer oversees restraint/enabler usage within the facility. The service currently has four residents using a restraint and two residents voluntarily using enablers. A register for restraints and enablers is maintained. The restraint approval committee reviewed restraint use. Staff were trained 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.

The infection control programme was appropriate for the size and complexity of the service. The infection control officer (clinical manager) was responsible for coordinating/providing education and training for staff. The infection control officer had attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control officer used the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	48	0	0	1	0	0
Criteria	1	99	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman has policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights. Families and residents are provided with information on admission, which included the Code of Rights. Staff receives training about resident rights at orientation and as part of the annual in-service calendar. Resident rights/advocacy staff training occurred in May 2014. Interviews with 10 caregivers (five rest home and five hospital) demonstrated an understanding of the Code of Rights principles.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Eleven of 11 resident files sampled (five from the rest home, five from the hospital and one from the serviced apartments) have a signed admission agreement and consents.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping.</p>
<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 organisational complaints policy is being implemented at Malvina Major Village. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There have been six complaints registered in the last year (four written and two verbal). All complaints have been managed in line with Right 10 of the Code of Rights. Concerns and complaints are discussed at relevant meetings. One Health and Disability Commissioner complaint from September 2014 has been closed May 2015. Discussion with residents and relatives confirmed they were provided with information on the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The information pack provided to residents on entry includes the Code of Rights information on how to make a complaint. On entry to the service, the village manager or the clinical services manager will discuss the information pack with the resident and their family/whānau. Advocacy brochures are displayed on the noticeboard on each floor. Advocacy is brought to the attention of residents and families on admission and via resident meetings, relatives meetings and the information pack.</p> <p>Interviews with nine residents (five rest home and four hospital) and five relatives (hospital) identified they were aware of their rights and could approach the managers at any time if they have concerns.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>During the audit, staff demonstrated gaining permission prior to entering resident private areas. All care staff interviewed demonstrated an understanding of privacy. Residents and family members interviewed confirm that staff promote resident independence wherever possible and that resident choice is encouraged. Residents values and beliefs information are gathered on admission with family involvement and is integrated with the residents' care plans. Care plans reviewed identified specific individual likes and dislikes. This includes cultural, religious, social and ethnic needs. Interviews with 10 caregivers identified how they get to know resident values, beliefs and cultural differences. There is an abuse and neglect policy implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect staff training occurred in May 2014.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Residents who identify as Māori have their cultural values identified on admission. On the day of the audit, one resident identified as Māori. There is an established Māori health plan. Cultural needs are addressed in the care plan. Family/whānau involvement is encouraged in assessment and care planning. Staff receive cultural awareness training. Links are established with disability and other community representative groups as requested by the resident/family.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Individual cultural needs/requirements, spiritual values and beliefs are identified on admission. Values and beliefs information is integrated into the residents' care plans. Residents and family members interviewed, confirm that the values and beliefs of residents are considered. Staff recognise and respond to values, beliefs and cultural differences. Weekly church services are held in a chapel at the service.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Staff were aware of the actions they should take in the event where they believe a staff member is not maintaining a professional approach to practice.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>Ryman Healthcare has a Ryman Accreditation Programme (RAP) that includes annual planning and a suite of policies/procedures to provide rest home and hospital care. Policies are reviewed at an organisational level. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly.</p> <p>Ryman Malvina Major provide services that adhere to the health & disability services standards. A quality improvement programme that is being implemented includes performance monitoring.</p> <p>There are human resources policies/procedures to guide practice and an annual in-service education programme that is incorporated into the RAP. There is evidence at Malvina Major that the in-service programme is being implemented. There is a journal club for registered nurses (RN) and enrolled nurses held two monthly in conjunction with the RN meetings.</p> <p>There are implemented competencies for caregivers and qualified nurses. Core competency assessments and induction programmes are being implemented at Malvina Major. RNs have access to external training.</p> <p>The service has been awarded a continuous improvement around the delivery of palliative care services and bowel management.</p> <p>Residents interviewed (five rest home and four hospital) and relatives (five hospital) were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<p>Full information to residents and family/representatives is provided at entry . Families are involved in the initial care planning and ongoing care. Regular contact is maintained with family, including if an incident or care/medical issue arises. Family members interviewed confirmed they are notified following a change of health status of their family member. Fifteen accident/incidents forms on the VCare system identified the family had been notified following the accident/incident. There is an interpreter policy and contact details of interpreters are available.</p>

communication.		
<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>Malvina Major is a Ryman Healthcare retirement village. The service provides rest home and hospital level of care for up to 120 residents in the care centre. Twenty serviced apartments have been certified as suitable to provide rest home level care. There were three rest home residents in serviced apartments. The two floors are each 60-bed units. There are 40 rest home beds and 20 dual-purpose beds on the first floor and 60 hospital beds on the second floor. There were 15 rest home residents in dual-purpose beds. There were 113 residents in the facility on the day of audit including 57 rest home and 56 hospital level residents (including one respite care).</p> <p>There were no residents under YPD or medical component of certification</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Quality objectives and quality initiatives from an organisational perspective are set annually, and each facility then develops their own specific objectives. Village objectives for 2014 have been evaluated (link CI 1.1.8.1). 2015 village objectives include; pride in our place (environment and presentation), reaching your potential (education, supporting new starters and growing champions), stop, think and be safe, systems that support you (VCare, InterRAI, full rosters, annual leave management) and making a difference – showing we care.</p> <p>The village manager has been in the role for one year and 10 months, with experience as a hotel manager and holds a diploma in hotel management. The assistant manager recently appointed to the role, was on leave the day of audit. The clinical services manager/RN was appointed October 2014 and has experience in quality and risk management systems and mental health services. She has support from two experienced unit coordinators (RNs), who have been with the service many years.</p> <p>Management are supported by a regional manager (fortnightly visits) and clinical quality auditor (at head office).</p> <p>The village manager has maintained at least eight hours to date, of professional development activities related to managing a village, which includes the Ryman leadership programme and village manager study days.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of</p>	FA	<p>Ryman policy outlines manager availability including on call requirements. During a temporary absence, the assistant manager and clinical services manager will cover the manager's role. The assistant manager covers administrative functions and the clinical services manager oversees clinical care. The regional manager provides oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>

<p>timely, appropriate, and safe services to consumers.</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 principles.</p>	<p>FA</p>	<p>Malvina Major is implementing the Ryman Accreditation Programme (RAP), which links key components of the quality management system to village operations. There are full facility RAP meetings monthly.</p> <p>Outcomes from the RAP committee are reported across various meetings including the full facility, registered nurse and care assistants meetings. Meeting minutes include discussion about the key components of the quality programme, including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Health and safety and infection control meetings are held three monthly. Clinical meeting minutes were sighted. Interview with staff confirmed an understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room.</p> <p>Relative survey was last completed February 2015. Results have been collated with annual comparisons for each service. Benchmarking occurs. Results were fed back to participants through resident and relative meetings.</p> <p>The RAP prescribes the annual internal audit schedule that has been implemented at Malvina Major. Audit summaries and QIPs are completed where a non-compliance is identified (<90%). Issues and outcomes are reported to the appropriate committee, for example RAP, health and safety. QIPs reviewed are seen to have been closed out and resolved.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets (eg, falls). Falls prevention strategies implemented are new carpets with markings that alert residents to slight change in gradient, new LED lighting and new handrails. Falls prevention management includes intentional rounding traffic light tags on mobility aids, traffic light transfer mobility guides in resident bedrooms, electric hi-lo beds, ongoing falls assessment and exercises by the physiotherapist, sensor mats, and appropriate footwear. The service has a 'lounge carer' in the afternoons in the hospital unit to monitor high falls risk residents. The physiotherapist completes hoist and safe manual handling training for staff.</p> <p>A health and safety, and risk management programme is being implemented at Malvina Major. The combined health and safety, and infection control committee meets three monthly and discussion of incidents/accidents and infections is discussed and documented. There is a current hazard register. The service holds the tertiary</p>

		level of accident compensation corporation (ACC) partnership. The service has an active return to work and employee assistance programme.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Malvina Major collects monthly incident and accident data and completes electronic recording of events on the VCare system. Monthly analysis of incidents (by type), is undertaken by the service and reported to the various staff meetings. Data links to the organisations benchmarking programme, and the data used for comparative purposes. QIPs have been created when the number of incidents exceeded the benchmark. Fifteen accident/incident forms (six rest home and nine hospital), identified timely RN assessment and post falls assessments where required. QIPs were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications.</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>	FA	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are job descriptions for RAP officers. Appropriate recruitment documentation was seen in the 14 staff files reviewed. Performance appraisals were current in all files reviewed. Interview with caregivers and RNs inform management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation.</p> <p>There are 112 caregivers with the following qualifications. Thirteen have completed Level II Foundations; 27 have completed ACE Core; 19 have completed ACE Dementia; 18 have completed ACE Advanced; 18 have completed National Certificate Core Competencies; 17 have completed National Certificate Residential and there are nine Foreign Trained Nurses. Caregivers complete yearly comprehension surveys, which includes researching policies and procedures.</p> <p>There is an annual training plan that aligns with the RAP that is being implemented. The clinical services manager oversees the education programme. Staff catch-up folders contain education content for staff to read and sign if they were unable to attend training. There is an aged care education assessor (employed 17 hours a week) to support staff working towards the national standards.</p> <p>Ryman ensures RN are supported to maintain their professional competency, including attending the two monthly journal club meetings and InterRAI training through the Ryman programme. Five RNs and the clinical services manager are trained in InterRAI. A register of current practicing certificates is maintained.</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 organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. A fulltime clinical services manager oversees the care centre. Each unit (rest home and hospital) in the care centre has a RN Unit coordinator. The serviced apartment coordinator is an enrolled nurse. In the serviced apartments, there are three care staff on the morning and afternoon shifts with staggered finishing times. From 10 pm, rest home staff and the hospital RN cover the serviced apartments.</p> <p>There is at least one registered nurse on duty 24/7. Interviews with care staff informed the registered nurses are supportive and approachable. Interviews with residents and relatives indicated there are sufficient staff to meet resident needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files reviewed were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. This information is entered into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse, including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The village manager and clinical services manager screen all potential residents prior to entry and record all admission enquires. Nine residents (five rest home and four hospital) and five relatives (hospital) interviewed, confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the village manager. The admission agreement aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge,</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Transfer documentation was sighted on the day of the audit in two resident files reviewed. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the residents' condition.</p>

or transfer from services.		
<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>PA Moderate</p>	<p>Twenty two medication charts were sampled (10 hospital, 10 rest home and two rest home level residents located in the serviced apartments). The service uses four weekly medico packs. Medication charts have photo identification. The RN checks blister pack medications on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Staff sign for the administration of medications on medication sheets held with the medicines. Shortfalls were identified around the signing of packed regular medications and non-packaged medications on the signing sheet. Expired medications were found in the hospital unit.</p> <p>RNs, enrolled nurses or senior caregivers administer medications. Annual medication competencies are completed. Allergies are identified on the medication record. There were two residents self-medicating on the day of audit. Both residents had assessments for this purpose in their files and a locked drawer to store the medication in their room.</p> <p>The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. The medication fridge temperature monitoring was inconsistent in the hospital unit. Not all medication charts reviewed identified a three monthly GP review.</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 a head chef (qualified City Guild), who is supported by another chef, chefs assistant and two dishwashers each day. The head chef is a health and safety representative on the health and safety committee. All staff have been trained in food safety and chemical safety. There is a four weekly seasonal menu that has 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 review and at other times such as resident 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 as vegetarian and pureed/soft meals are provided. Food is delivered in scan boxes to each area and served from bain maries. The serving temperature in the bain maries are monitored and recorded daily. The service is well equipped with steam bake, gas and electric cooking. Fridge and freezer temperatures are checked daily. Chilled goods temperature is checked on delivery. Food temperatures are monitored and recorded daily. 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 attends resident meetings and has contact with residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this decision to resident/family. Any potential residents declined entry is referred back to the referring agency for appropriate placement and advice.</p>

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information gathered on admission from discharge summaries, referral letters, medical notes, and from discussion with the resident/family is used to develop the initial assessment care plan and the initial resident long-term care plan. Risk assessment tools are available for use on admission and reviewed six monthly or as the resident's health status changes. Twenty-five residents have been assessed using InterRAI and the remaining residents will have an InterRAI assessment as their review falls due. There have been no new admissions requiring long-term care since 1 July 2015. InterRAI initial assessments and assessment summaries were evident in printed format in the one file reviewed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed were comprehensive, and demonstrate service integration and input from allied health. All resident care plans sampled were resident centred and support needs were documented in detail. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Short-term care plans for infections were evidenced in three hospital and four rest home files, and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. All other changes in health status had a long-term care plan completed. There was evidence of service integration with documented input from a range of specialist care professionals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans reviewed included documentation that meets the need of the residents. Where resident needs had changed, care plans had been updated. Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members interviewed stated that care and support is good, and they are involved in the care planning. Caregivers and RNs interviewed state there is adequate equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. Wound management and monitoring occurred as planned. All have appropriate care documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Care plans document allied health input. On the day of the audit, there were seven residents with 13 wounds including four pressure areas (three grade two and one grade one). All wounds included an assessment,

		management plan and ongoing evaluation. A sample of wounds reviewed in detail included a link to the long-term care plan. There is wound care specialist input into one chronic ulcer.
<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>	FA	<p>There is a full time activity coordinator and a part time activity assistant in each of the hospital and rest home areas and a full time activity coordinator in the serviced apartments.</p> <p>The activity team meet yearly to plan the joint events for the year and then on a monthly basis to develop these events further. Each area has a monthly programme, which is given to every resident and a copy is placed on the notice board. Residents are reminded daily of the activities for that day.</p> <p>On the day of audit, residents were observed being actively involved in a variety of activities in the rest home, hospital and serviced apartments.</p> <p>Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family etc. This is used to develop a resident centred activity care plan, which is reviewed and evaluated six monthly at the same time as the care plan.</p> <p>The activities include outings, a weekly church service, and visits by a dog, local schoolchildren, quizzes, exercises and current affairs. The local Probus club meets at the facility and residents who are members go along to the meetings.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff, through two monthly resident meetings, yearly survey or following activities. There is also a six monthly relatives meeting.</p>
<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 have been evaluated by the registered nurses six monthly, or when changes to care occur in the files reviewed. Evaluations were documented and included progress to meeting goals. There was documented evidence of care plans being updated as required.</p> <p>There was at least a three monthly review by the medical practitioner in all resident files reviewed.</p> <p>There are short term care plans to focus on residents with an infection. STCPs reviewed were evaluated regularly. All other acute changes in health status were updated in LTCPs on VCare.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	FA	<p>Discussions with the registered nurses (RN) identified that the service has access to external and specialist providers. The service facilitates access to other medical and non-medical services. The RN could describe this. Referral documentation was sighted on the day of the audit in one resident file reviewed.</p>

<p>(Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies to guide staff in waste management, including general and medical waste. Staff interviewed were aware of practices and processes outlined in the relevant policy. Gloves, aprons and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. The cleaners store chemicals in a caddy, which they take with them when cleaning.</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>	<p>FA</p>	<p>The service is divided into two units on two levels, hospital and rest home. There is a nurses' station within each unit. The building has a current building warrant of fitness that expires 20 November 2015. Currently the full-time gardener/health and safety representative is overseeing the facility maintenance until a full-time maintenance person is appointed in four weeks. Daily maintenance requests are addressed and signed off (sighted). There is a 12 monthly planned maintenance schedule in place, which includes the calibration of medical equipment and functional testing of electric beds and hoists. Ryman has a trained electrical tester and equipment to carry out annual electrical testing. Hot water temperatures are monitored and recorded three monthly. Hot water temperature recordings sighted were below 45 degrees Celsius. Contractors are available 24/7 for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space around the facility for storage of mobility equipment. Rest home and hospital residents have access to the front car park area, which is level and well maintained. The service employs grounds and garden staff who maintain the external areas. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. There is an outdoor designated smoking area.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All resident rooms have ensuites. Communal toilets are located near the lounges. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All residents rooms are single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites. Residents have been encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Each unit has a lounge and dining area. There are seating alcoves and family rooms available for quiet private time or for visitors. The communal areas are easily and safely accessible for residents.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Ryman has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits were completed as per the RAP programme. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals. Material safety data sheets are displayed in the cleaning cupboards. The laundry and cleaning areas have hand-washing facilities.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies to guide staff in managing emergencies and disasters. Emergencies and first aid is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Malvina Major building has an approved fire evacuation plan dated 9 July 1998. Fire drills occur six monthly. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is available and the service has an arrangement to hire a generator. There are civil defence supplies in the facility and adequate water storage. Call bells are evident in residents' rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There is thermostatically controlled heating throughout the facility. All rooms have external windows with natural sunlight access. All residents interviewed stated they were happy with the temperature of the facility.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. There is an infection control (IC) responsibility policy that included chain of responsibility and an Infection Control Officer job description. The infection control programme is linked into the quality management system via the RAP. The infection control committee meeting is combined with the health and safety committee, which meet two monthly. The facility meetings also include a discussion of infection control matters. The IC programme is reviewed</p>

infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		annually from head office and is directed via the RAP annual calendar.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control committee representatives include the rest home unit coordinator (who is the infection control coordinator) and the clinical services manager. The facility has access to an external infection control nurse specialist, district health board infection control group, GPs and expertise within the organisation. The infection control officer attended external infection control education February 2015. There are regular Ryman teleconferences with other facility infection control officers, which includes twice-yearly education.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are comprehensive infection control policies that are current and reflected the Infection Control Standard SNZ HB 8134:2008, legislation and good practice. Policies and procedures from an external infection control specialist have been implemented. The infection control policies link to other documentation and cross reference where appropriate.
Standard 3.4: Education	FA	The infection control officer is responsible for coordinating/providing education and training to staff. The

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>infection control officer has appropriate training for the role. The induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education is expected to occur as part of providing daily cares.</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>	<p>FA</p>	<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 service provided. Infections were included on a register and monthly reports completed by the infection control officer. Monthly data is reported to the combined infection control and health and safety meetings. Staff are informed on infection control matters, trends and quality improvements through the variety of meetings held at the facility. The infection control programme is linked with the RAP. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. The service has raised a recent QIP in response to an upward trend in urinary tract infections (UTIs). Acidophilus yoghurt for residents prone to UTIs has been commenced. There is close liaison with the GPs that advise and provide feedback/information to the service. There have been no outbreaks. 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 is actively minimised.</p>	<p>FA</p>	<p>There is a restraint policy in place, which states the organisation's philosophy to restraint minimisation. 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. On the day of audit, there were five residents with restraint and no residents with enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to</p>	<p>FA</p>	<p>The clinical services manager is the restraint officer for the facility, and has defined responsibilities included the job description. The approval committee meet six monthly and comprise of the restraint officer, GP, physiotherapist, activity officer and unit coordinators. There is ongoing education including restraint minimisation and challenging behaviours. Quality and clinical meetings include discussion on restraint. Staff carry out and record restraint monitoring, including cares delivered during the restraint period.</p>

service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments are undertaken by the restraint officer/registered nurses in partnership with the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Ongoing consultation with the resident and family/whānau was also identified. A restraint assessment form was completed for the five residents requiring restraint (sighted). Assessments consider the requirements as listed in Criterion 2.2.2.1 (a) - (h). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint officer is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation considers the areas identified in 2.2.4.1 (a) – (k). Evaluations occur six monthly (or earlier as required), as part of the ongoing reassessment for residents on the restraint register and as part of their care plan review. Families are included as part of this review where possible.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint usage throughout the Ryman organisation is monitored regularly. The review of restraint use is discussed at the approval group meetings and relevant facility meetings. The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme is in place, which includes restraint competencies. Internal restraint audit completed June 2014 achieved 100% result.</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</p> <p>Moderate</p>	<p>Medication policies align with accepted guidelines. The service uses four weekly blister packs. Medication charts have photo identification and allergies documented. There is a signed agreement with the pharmacy. The medication folder includes a list of specimen signatures. Nineteen of 22 medication administration signing sheets reviewed had regular packed medication administered as prescribed. Fourteen of 22 medication administration signing sheets reviewed, had regular non-packaged medication administered as prescribed. No expired medications were found in the rest home medication cupboard. Seventeen of 22 medication charts reviewed had evidence of three monthly GP reviews. There was evidence of weekly recording of medication fridge temperatures in the rest home.</p>	<p>(i) Three of 22 medication administration signing sheets for packed regular medications have signing gaps. (ii) Eight of 22 medication administration signing sheets have signing gaps for regular non-packaged medications. (iii) There were expired medications in the medication cupboard in the hospital. (iv) Five of 22 medication charts did not evidence three monthly GP reviews. (v) Medication fridge temperatures in the hospital were not consistently recorded weekly.</p>	<p>i) and ii) Ensure all medications are signed on the signing sheet when administered. (iii) Ensure there is a system in place for the checking of expiry dates. (iv) Ensure GP reviews medication charts at least three monthly. (v) Ensure fridge temperatures are recorded weekly.</p>

				30 days
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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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service is committed to continuous quality improvement. Quality improvement plans (QIPs) are developed for any deficits identified as of a result of concerns/complaints, internal audits, below average quality indicators and suggestions for improvement. Malvina Major has participated in two research projects within the last year being;</p> <p>1) Pharmac pilot in the use of ‘as required’ antipsychotic medication in dementia, to reduce incidence of challenging behaviours, and 2) Massey University pilot of the whole body vibration exercise intervention to reduce the number of falls. Two QIPs implemented; 1) palliative care focus and 2) bowel management have been evaluated and evidence positive</p>	<p>1) The service identified an improvement required around end of life care following a clinical review of palliative care residents. Palliative/end of life care was included as a key focus for the 2014 village objectives that would see Malvina Major as the provider for best palliative care for residents and their families. A meeting was held with the management team and key stakeholders including the general practitioner (GP) and hospice clinical educators to develop strategies and goals that would improve palliative care over the 24-hour period. Village and care centre residents involvement and feedback sought on the project through regular meetings. Palliative care discussion is held at all service meetings.</p> <p>The following goals have been implemented over the period April 2014 to April 2015:</p> <p>a) A number of palliative care education sessions and modules (internal and external), were delivered by hospice educators and 121 staff</p>

		<p>changes in nursing practice.</p>	<p>attended the sessions. Staff palliative care champions have been developed. Care staff who attended palliative care education are rostered to work alongside the RNs caring for palliative care residents and their families. The hospital coordinator attended the Death and Dying Symposium in May 2015. All RNs have completed syringe driver competency. A staff photo gallery has been set up for residents and families to recognize individual staff members.</p> <p>b) Palliative care assessment tools and questionnaires were developed from a case study to promote critical thinking. Family meetings are held in consultation with the GP and clinical staff as soon as residents require palliative care. The service has developed a close relationship with hospice staff and specialists with early referrals to hospice, further enhancing the resident and family end of life experience. Family's emotional and spiritual needs are being met through early referral to hospice and/or pastoral support. Palliative care kits have been created to provide for a calm and peaceful physical environment, which includes candles, throws, music aromatherapy and artistically set tea trays. Debrief sessions are held for staff after the loss of palliative residents.</p> <p>c) Improved pro-active prescribing ensures there are adequate palliative care medications in stock that can be accessed at any time for residents who require palliative care medications. The service has purchased additional and specific equipment to meet the needs of the palliative care residents including superior high-pressure area rating alternating air mattresses and other pressure relieving devices and syringe drivers. The equipment is checked on a regular basis.</p> <p>Regular evaluations have been documented throughout the year. Meeting minutes sighted evidence discussion at all levels around the palliative care service. Improvements include; positive feedback to the teams from families post passing of their loved ones through cards and letters, improved and open communication with families around the dying process, more consistent level of care across all shifts for palliative care residents and increased staff confidence in the care of palliative care residents.</p> <p>There is documented evidence of increased referrals to Malvina Major for palliative care. For the period 1 January 2014 to 31 July 2014 there were eight palliative care referrals from hospice. In the period 31 July 2014 to 1 January 2015 there were 15 referrals from hospice for</p>
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			<p>palliative care.</p> <p>2) The service identified a need to improve the quality and consistency of bowel chart documentation and management. A review was undertaken of the existing document that found there was limited information recorded regarding resident elimination patterns and frequency. The bowel chart was revised to include the Bristol Stool Chart bowel types and clinical guide for action. The bowel chart covers a six-week period for all shifts. The clinical management team introduced staff to the new bowel chart, providing education (with continence/bowel management representatives and educational DVD) on bowel management and the new chart. Staff were given the opportunity to provide feedback during the trial period. The trial was successful and implemented across all clinical areas at Malvina Major. When the document was due for review at organisational level, the Malvina Major bowel management chart was endorsed and rolled out through the RAP programme across all the Ryman Villages in New Zealand and Australia.</p> <p>The quality improvement project has been evaluated regularly. The following improvements were recorded: Increased staff knowledge and awareness of prevention of constipation and good hydration, bowel management and use of the bowel chart is included in care staff orientation, early interventions for constipation, less need for GP intervention, proactive GP prescribing of laxatives for residents on admission as required and fewer admissions to hospital for bowel related disorders. Five residents in the hospital wing prone to constipation and falls were monitored pre and post redesign of the bowel chart. All five residents (data sighted) had reduced the number of falls since the introduction of the redesigned bowel chart. The reduction in falls has been due to less constipation therefore less agitation and abdominal discomfort triggering the need for the resident to attempt frequent trips to the toilet.</p>
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End of the report.