

Rowena Jackson 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:	Rowena Jackson Retirement Village Limited
Premises audited:	Rowena Jackson Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 20 April 2015 End date: 21 April 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:	152

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Rowena Jackson Retirement Village is a Ryman Healthcare facility, situated in Invercargill. The purpose of this audit was to assess the facility for certification. The Rowena Jackson facility is modern and spacious. The care facility provides rest home, hospital and dementia level care. The village manager is a registered nurse and is experienced in village management, having been in the role for 10 years. She is supported by a clinical manager (registered nurse) who oversees the care centre. There are systems, processes, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme. The service has been actively working on education and training for staff, reducing turnover of staff and improving attendance at activities. Feedback from residents and families was very positive about the care and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There is one area of continuous improvement around implementation of the quality programme.

Two improvements are required around conducting annual staff appraisals and timeframes for completion of aspects of care planning.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Ryman Rowena Jackson endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Maori Health Plan and implemented policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are being implemented to support residents' rights. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Informed consent is sought and advanced directives are appropriately recorded. Complaint processes are being implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with 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.		Some standards applicable to this service partially attained and of low risk.
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Rowena Jackson has implemented the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative

meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Rowena Jackson provides clinical indicator data for the three services being provided (hospital, rest home and dementia). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The systems reviewed evidenced each stage of service provision was developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. The residents interviewed confirmed that interventions noted in their care plans were consistent with meeting their needs. A sampling of residents' clinical files validated the service delivery to the residents. Where progress was different from expected, the service responded by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities were appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. The residents' files evidenced individual activities were provided either within group settings or on a one-on-one basis.

There was an appropriate medicine management system in place. Staff responsible for medicine management attended medication management in-service education and have current medication competencies. The residents who self-administer medicines do so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a central kitchen and on site staff that provide the food service. The kitchen staff had completed food safety training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant comply with legislation. There is a current building warrant of fitness in place. Appropriate systems, including preventative and reactive maintenance are in place to ensure the residents' internal and external environment and equipment are safe and facilities are fit for their purpose. Residents and family described the environment as meeting their needs. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

There is protective equipment and clothing and staff were observed to use them. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems included appropriate monitoring systems to evaluate the effectiveness of these services.

Essential emergency and security systems are in place with regular fire drills. Call bells allow residents to access help when needed in a timely manner.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are comprehensive policies and procedures that meet the restraint standards. There is a restraints officer with defined responsibilities for monitoring restraint use and compliance of assessment and evaluation processes. The service has maintained a restraint free environment. There are two hospital residents with enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities. Outbreaks in 2014 have been managed appropriately.

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	42	0	2	0	0	0
Criteria	1	90	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented and align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents have been provided with information on admission which includes the Code. Staff have been provided with training around resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with nine caregivers (one serviced apartments, two rest home, four hospital, and two dementia) demonstrate an understanding of the Code. Resident rights/advocacy training has been provided. Residents interviewed (eight rest home and five hospital) and relatives (three rest home, two hospital and two dementia special care unit) confirm staff respect privacy, and support residents in making choice where able.</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 consent.</p>	FA	<p>Systems are in place to ensure residents and, where appropriate, their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreement. The clinical staff reported informed consent is discussed at the time the resident is</p>

		admitted to the facility and when additional consent requires to be obtained, such as flu vaccinations. Staff interviewed demonstrated good understanding of informed consent processes. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are obtained, where residents have named EPOAs and these were reviewed on residents' files. Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent, and confirmed informed consent information has been provided to them and their choices and decisions are acted on. Advance directives are recorded and located on residents' files.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interviews with the village manager, and the clinical manager confirm practice is consistent with policy. Residents interviewed confirm that they are aware of their right to access advocacy and relatives confirm that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	D3.1h: Residents and relatives interviewed confirmed that family and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. The activities policy encourages links with the community. Activities programmes include opportunities to attend events outside of the facility. Residents are assisted to meet responsibilities and obligations as citizens and are encouraged to remain involved in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and supporting documents are being implemented. The village manager has the overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A feedback form has been completed for each complaint recorded on the complaint register. The number of complaints received each month is reported to staff via the various meetings. A complaints register has been maintained that includes relevant information regarding the complaint. Documentation including follow up letters and resolution was available. Verbal complaints have

		been included and actions and response are documented. Discussion with residents and relatives confirm they were provided with information on the complaints process on admission including the special care unit information booklet.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family members are provided with a welcome pack which includes information about the Code. They are also provided with an opportunity to discuss information prior to admission. Information is also given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. Large print posters of the Code and advocacy information are displayed through the facility. The individual unit resident/relative meetings also provides an opportunity for residents and relatives to raise issues/concerns (minutes sighted). Residents and relatives interviewed advised that information has been provided around the Code. The village manager and senior clinical staff have an open door policy for concerns or complaints. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement and the village information book.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ryman has policies that support resident confidentiality, privacy, collection and storage of information, and access to health information (disclosure). A tour of Rowena Jackson confirms there is the ability to support personal privacy for residents and staff were observed to be respectful of residents' privacy. Resident files are stored out of sight. Staff could describe definitions around abuse and neglect that align with the Ryman policy. Relatives interviewed stated that the care provided was very good. Interviews with residents confirm their values and beliefs were considered. Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified on admission with family involvement and integrated with the residents' care plan.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their	FA	Ryman has a Maori health plan with supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care

individual and cultural, values and beliefs.		planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Special events and occasions are celebrated and this could be described by staff.
<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	Beliefs and values are discussed on admission and incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Ryman Accreditation Programme (RAP) full facility (including all staff) meetings occur monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager and registered nurses confirm an awareness of professional boundaries. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Specific training is provided for care staff who work in the dementia unit.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	Ryman Healthcare has a Ryman Accreditation Programme (RAP) that includes an annual planning and a suite of policies/procedures to provide rest home care, hospital care and dementia care. Policies are reviewed at an organisational level and input is invited from facility staff. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. A number of core clinical practices also have education packages for staff which are based on their policies. Clinical indicator data is collected against each service level and reported through to head office for monitoring. Feedback is provided to staff via the various meetings that are determined as part of the RAP. Quality Improvement Plans (QIP) are developed where thresholds exceed expectation. Vcare is the electronic system used by all sites to report relevant information

		<p>through to head office, and is seen to be used at Rowena Jackson.</p> <p>Services are provided at Rowena Jackson that adhere to the health & disability services standards. There is a quality improvement programme that is being implemented that includes performance monitoring. 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 Rowena Jackson that the in-service programme is being implemented. There is evidence of opportunistic education being provided at handovers. Residents and relatives interviewed 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 communication.</p>	FA	<p>There is an incident reporting policy, and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. A sample of incident forms reviewed identified that family were notified following a resident incident and this was confirmed on resident and relative interviews. Interpreter policy and contact details of interpreters is available. The information pack and admission agreement included payment for items not included in the services. A specific introduction to the dementia special care unit booklet provides information for family, friends and visitors visiting the facility.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ryman Rowena Jackson is certified to provide rest home, hospital and dementia level care. The care centre is part of the wider retirement village. The serviced apartment area is also certified for rest home level care. On the days of audit there were seven rest home residents in the serviced apartments, 52 rest home residents, 69 hospital residents and 24 dementia residents in the special care unit.</p> <p>There is a documented ' purpose, values, scope, direction & goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the Ryman Accreditation Programme (RAP) that includes a schedule across the year. Ryman Healthcare have operations team objectives 2015 that include a number of interventions and actions.</p>

		<p>Each service also has their own specific RAP objectives. The 2015 objectives for Rowena Jackson have been identified. Progress towards objectives is updated as part of the RAP schedule, with the reviews of the facility objectives having been conducted in April and August. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and psychogeriatric care. There is a medical component to the certificate.</p> <p>The village manager at Rowena Jackson is a registered nurse non clinical and has been in the role for 10 years. The village manager attends the annual Ryman manager's conference and manager forums. She is supported by a clinical manager (RN) who oversees clinical care. The management team is supported by the Ryman management team including a regional manager who was present on the days of audit.</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 timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the assistant village manager covers the manager's role with support from the clinical nurse manager and regional manager. A review of the documentation, policies and procedures and from discussion with staff, identified the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</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>	CI	<p>Rowena Jackson has implemented the Ryman accreditation programme (RAP) system. Quality and risk performance is reported across the various facility meetings. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.</p> <p>The service has policies and procedures and the RAP programme defines systems to provide an 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. Policy and procedure review is coordinated by head office, with facility staff having the opportunity to provide feedback. Facility staff are informed of changes/updates to policy at the various staff meetings.</p> <p>Key components of the quality management system link to the RAP committee at Rowena Jackson, who meet monthly. Quality indicator</p>

		<p>reports are sent to head office (Christchurch) with provision of a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical manager collected across rest home, dementia and hospital services as well as staff incidents/accidents. The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. The Rowena Jackson health and safety and infection control committees meet bimonthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation.</p> <p>The internal audit schedule monitors compliance with the RAP programme. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. QIP's reviewed for 2014 have been closed out once resolved.</p> <p>There is a comprehensive H&S and risk management programme in place. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects incident and accident data. A sample of incident forms selected evidence that all forms had been completed appropriately including investigation and preventative actions. All had been reviewed by the clinical manager. Resident files were traced and all reported incidents had an accompanying incident form and the incident documented in progress notes. Incidents/accidents, unplanned or untoward events are fed back to staff so that improvements can be made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark for example medication errors and pressure injuries. Discussions with service management, confirms an awareness 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</p>	<p>PA Low</p>	<p>The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>authorities. Relevant documentation was seen in staff files reviewed with the exception of annual appraisals for all employees. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained. Policy includes the requirements of skill mix, staffing ratios and rostering. On interview, the management team inform a reduction in staff turnover has been identified as one of the facility's objectives for 2014 and 2015. Interviews with staff confirm that management are supportive and responsive.</p> <p>The training plan for 2014, which aligns with the RAP, has been completed. Additional education sessions have also been provided. Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff and actively support the Health Ed Trust ACE Programmes and provide incentives to their staff to undertake both the general and dementia modules. There are currently 14 permanent caregivers employed in the special care unit and all have completed dementia standards. Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Staff advise that there are sufficient staff on duty at all times and interviews with residents and relatives confirm this. Staff and management inform there is capacity to increase staff numbers based on resident acuity, and there is access to both casual staff and part-time staff to cover unexpected absence.</p> <p>The serviced apartments are currently managed by an enrolled nurse with oversight from the coordinator based in one of the hospital units. A four weekly roster for each service area ensures that there are sufficient staff on duty.</p> <p>There is at least two registered nurses on duty at all times. The caregivers cover a mix of long and short shifts. There are designated cleaners, laundry staff, activities staff, gardeners, and administration staff. The clinical manager works 40 hours per week and oversees the clinical care of all residents. The village manager also works 40 hours</p>

		<p>per week.</p> <p>In the dementia unit there is an RN on a morning shift Monday to Sunday, 7 – 3.30.</p> <p>Activities are provided seven days a week in the dementia unit between 9am and 8pm.</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>	FA	<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 into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked cupboard in each area. Care plans and notes reviewed were legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. Ryman utilise a computerised care programme for all residents (V-care) and this is linked to head office. The programme is used for logging of all incidents and accidents and in analysis of same.</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>	FA	<p>The entry and assessment processes are recorded. Information specific to this service is recorded and communicated to residents, family, relevant agencies and staff. This facility operates 24 hours a day, seven days a week. The facility information pack is available for residents and their family and contains all relevant information.</p> <p>Residents' admission agreements evidenced resident and /or family and facility representative sign off. The needs assessments were completed for rest home, hospital and dementia levels of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There was appropriate communication between families and other providers in the residents' files that demonstrated transition, exit, discharge or transfer plans were communicated, when required. Transition, exit, discharge, or transfer form / letters / plan were located in residents' files, where this was required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medicine management system meets guidelines and current legislative requirements. Registered staff interviewed confirmed that prescribed medications were delivered to the facility and checked on entry. The medication areas, including controlled drug storage areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug registers were maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridges had temperatures conducted and recorded. All staff authorised to administer medicines had current competencies. Medication rounds were observed and evidenced the staff members were knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records were maintained, as were specimen signatures. Staff education in medicine management was conducted in 2014.</p> <p>Medicine charts evidenced residents' photo identification, medicine charts were legible, as required (PRN) medication was identified for individual residents and correctly prescribed, three monthly medicine reviews were conducted and discontinued medicines were dated and signed by the GPs. The residents' medicine charts recorded all medications a resident was taking (including name, dose, frequency and route to be given). The residents self-administering medicines at the facility did so according to policy.</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 food service policies and procedures are appropriate to the service setting with a four week seasonal menu reviewed by a dietitian. In interview, the head chef confirmed they were aware of the residents' individual dietary needs. The residents' dietary requirements were identified and documented. Copies of the residents' dietary profiles were kept in the kitchen. The kitchen staff were informed if resident's dietary requirements changed, confirmed at interview with the head</p>

		<p>chef. Safe food handling training was conducted in 2014.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. In interviewed, residents stated they were satisfied with the food service.</p> <p>The food temperatures were recorded as were the fridge, chiller and freezer temperatures. All decanted food was dated.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <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.</p>	FA	<p>The scope of the service provided is identified and communicated to all concerned. Management stated that a process to inform residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The residents would be declined entry if not within the scope of the service or if a bed was not available. The resident would be referred back to the referring service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The resident files reviewed identified that the needs, outcomes and goals were identified via the assessment process and recorded (refer to 1.3.3.3). The facility has processes in place to seek information from a range of sources, for example; family, GP, specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>The residents' files evidenced residents' discharge/transfer information from district health board (DHB) (where required) were available. The facility has appropriate resources and equipment, confirmed at staff interviews. In interviews, the RNs and clinical co-ordinators confirmed that assessments were conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plans reviewed were individualised and up to date. The residents' files were in hard copy, with records such as: wound assessments and wound care plans; falls assessments; pressure area assessments; pain assessments; weight monitoring and observation recorded on the computer. In the files reviewed the care plan interventions reflected the assessments and the level of care required.</p>

		Short term care plans have been developed, when required and signed off by the RN when problems were resolved. In interviews, staff reported they received adequate information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented, sighted in current GP progress reports and confirmed at GP interviews.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records were current. In interviews, residents and family confirmed their and their relatives' current care and treatments met their needs. Family communications were recorded in the residents' files. Nursing progress notes and observations charts were being maintained. In interviews staff confirmed they were familiar with the current interventions of the resident they were allocated. Review was conducted of computer records on wound care and review of resident files with wounds.
Standard 1.3.7: Planned Activities 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.	FA	The service implemented the Engage Activities Programme in August 2014, to increase attendance at activities. Activities staff education was provided on the engage activities programme prior to its implementation. Activities attendances are monitored and reviewed at monthly activities meetings. Residents' feedback is obtained from residents at residents' meetings and satisfaction surveys. Satisfaction survey conducted in October 2014 recorded that majority of residents expressed positive feedback about the programme. In interviews, the activities coordinators confirmed the activities programme meets the needs of the service group and the service had appropriate equipment. The diversional therapist and the activities coordinators plan, implement and evaluate the activities programmes. There are activities programmes for each service at the facility. Regular exercises and outings are provided for those residents able to partake. Interviews with residents, family and staff confirmed the activities programme included input from external agencies and supported ordinary unplanned/spontaneous activities including festive occasions and celebrations. There were activities assessments, care

		plans and care plan evaluations in residents' files reviewed.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly (link 1.3.3.3). There was evidence of multidisciplinary input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations.</p> <p>The residents' progress notes recorded the care provided to residents. When resident's progress was different than expected, the RN or the clinical co-ordinator contacted the GP, as required. Short term care plans were being utilised as required. The family were notified of any changes in resident's condition, confirmed at family interviews and evidenced in the progress notes reviewed. There was recorded evidence of additional input from professionals, specialists or multi-disciplinary sources, if this was required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (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>	FA	<p>Appropriate processes are in place to provide choices to residents in accessing or referring to other health and/or disability services. Completed referral forms / letters were sighted in some files reviewed. This included referrals to DHB specialists. Family involvement was recorded in the residents' progress notes. An effective multi-disciplinary team approach was maintained and progress notes detailed relevant processes were implemented.</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>	FA	<p>Staff interviewed reported they had received training and education on safe and appropriate handling of waste and hazardous substances. Staff training / education in chemical use was conducted in 2014.</p> <p>Observations provided evidence hazardous substances were correctly labelled and sluice facilities are provided for disposal of waste. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled were provided and used by staff. Material safety data sheets were available and accessible for staff.</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>In interviews, the maintenance staff stated that there is a preventative and reactive maintenance programme in place. External contractors are used for plumbing, electrical and other specialist areas. There is a calibration programme for medical equipment and electrical safety</p>

		<p>checks. Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment. A current building warrant of fitness is displayed and expires on 18 November 2015.</p> <p>In all areas of the facility corridors are wide enough to allow residents to safely pass each other; safety rails are secure and are appropriately located. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>External areas are available for residents and these are maintained and appropriate to the resident groups. Dementia unit has secure external area. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.</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>	FA	<p>In all areas of the service there are adequate number of communal showers, toilets and hand basins for residents. Separate toilet facilities are provided for staff and visitors. Toilets and showers are of an appropriate design and number to meet the needs of the residents. Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence. Hot water temperatures are monitored and maintained at a safe temperature.</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>	FA	<p>All bedrooms provide single accommodation and are personalised with resident's possessions. An adequate personal space is provided in bedrooms to allow residents and staff to move around safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate,</p>	FA	<p>In all areas of the facility adequate access is provided to the lounges, sitting areas and dining rooms. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these</p>

and accessible areas to meet their relaxation, activity, and dining needs.		areas and they do not want to participate in them.
<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>Cleaning and laundry policy and procedures are available. All linen is washed on site and there is adequate dirty / clean flow in the laundry. The laundry person was interviewed and described the management of laundry processes and services.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme. In interview the cleaner described the cleaning processes and knowledge of the use of chemicals. Safe and secure storage of chemicals is available and staff have appropriate and adequate access to these areas.</p> <p>Residents and family interviewed stated they were satisfied with the cleaning and laundry service.</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>Documented systems are in place for essential, emergency and security services. Information in relation to emergency and security situations is readily available/displayed for service providers and residents. There is emergency equipment stocked to a level appropriate to the service setting. The fire evacuation scheme for the facility is approved by the New Zealand Fire Service. The trial fire drill evacuations are held six monthly.</p> <p>There is at least one staff member on duty with a current first aid certificate. Emergency and security management education is provided as part of orientation and the in-service education programme.</p> <p>There is a call bell system in place that is appropriate to the resident group and setting. Call bells are accessible / within reach, and are available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.</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>Residents and family interviewed confirmed the facility is maintained at an appropriate temperature. Residents' rooms are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an IC responsibility policy that includes chain of responsibility and an IC officer job description. A registered nurse is the designated IC officer. There is an implemented infection control programme that is linked into the quality management system. Infection control matters discussed at the bimonthly health and safety and infection control meetings and the infection control committee includes a cross section of staff. The IC programme is set out annually from head office and is directed via the RAP annual calendar. The annual review policy states IC is an agenda item on the two monthly head office health and safety committee.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control committee is made up of a cross section of staff from areas of the service. The infection control committee is combined with the health and safety committee. The facility also has access to an infection control nurse specialist, public health, GP's and expertise within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>There are comprehensive infection control policies that are current and reflect the Infection Control Standard SNZ HB 8134:2008, legislation and good practise. These are across the Ryman organisation and are current and regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to staff. The IC officer (registered nurse) has completed appropriate IC training for the role. The induction package includes specific training around hand washing and standard precautions and the IC officer provides training both at orientation and on-going. Training on infection control has been provided. Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>The surveillance policy describes and outlines the purpose and</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>methodology for the surveillance of infections. Systems in place are appropriate to the size and complexity of the facility. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the RAP. There is close liaison with the GP's that advise and provide feedback /information to the service. Two outbreaks in 2014 were appropriately managed and reported.</p>
<p>Standard 2.1.1: Restraint minimisation 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. The policy identifies that restraint is used as a last resort. The service has been restraint free for over six years (link #1.2.3.6). There is one hospital resident with an enabler (bedrails and a lap belt) and one hospital resident with a lap belt enabler. Both enablers are utilised as a falls prevention measure and residents interviewed confirmed the use of the enablers. A monthly restraint and enabler register is maintained. The long term care plan includes the use of restraint/enablers, frequency of monitoring and required documentation. There are restraint monitoring guidelines in place. Types of enablers have been approved for use by the restraints committee.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>A selection of staff files identify that processes for employment have been completed. Participation in the ACE programme is a requirement for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly at all Ryman facilities. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on. Annual staff appraisals have been completed for 10 of 14 staff files reviewed.</p>	<p>Four of fourteen staff files reviewed did not have a current annual appraisal</p>	<p>Ensure that all employees have an annual appraisal completed.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p>	PA Low	<p>The residents' files are in hard copy, with some records such as: wound assessments</p>	<p>Residents' files reviewed in all service areas evidenced inconsistencies in</p>	<p>Provide evidence each stage of</p>

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>and wound care plans; falls assessments; pressure area assessments; pain assessments; weight monitoring and observation recorded on the computer. Residents' initial care plans and long term care plans recorded individualised residents' needs and specific interventions. Timeframes are not consistently adhered to in relation to: initial care plans; initial risk assessments; GP initial assessments; risk reassessments; and completion of long term care plans.</p>	<p>management of timeframes in relation to completion of initial care plans (one of fourteen); completion of risk assessments (seven of fourteen); completion of re assessments (four of fourteen); GP initial assessment (five of fourteen) and completion of long term care plans (two of fourteen).</p>	<p>service provision is conducted within specified time frames.</p> <p>90 days</p>
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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Rowena Jackson is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement plans (QIP) are completed where a noncompliance is identified. Repeat audit is required if results exceed the Ryman threshold and issues and outcomes are reported to the appropriate committee. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets. Weekly reporting to the regional manager includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix. QIP's reviewed are seen to have been closed out once resolved. The QIP process is seen to have been well embedded into day-to-day operations at Rowena Jackson and include clinically focused improvements.</p>	<p>Quality improvement activity at Rowena Jackson is guided by the Ryman Accreditation Programme (RAP) framework. To this end the facility has achieved a number of objectives for the 2014 year. Objectives for 2015 have been identified and are align with the various areas of service.</p> <p>a) Resident: response to resident and relative surveys, improvements around meals</p> <p>b) Clinical: wound care, medication management, pressure areas</p> <p>Objectives for 2015 include promotion of the engage activities programme, promoting happy healthy staff, ensuring staff are skilled in care and communication, education around V-care kiosk, and a manual handling project.</p>

			<p>Quality improvement projects for 2014 include implementation of the engage activities programme, reducing the incidence of infection, reducing staff incident and injury, managing health and safety/hazards within the facility, maintaining a restraint free environment, and reducing staff turnover.</p> <p>Progress towards objectives and QIP's is reported regularly (quarterly) with the last minute discussion in April. Updates are noted to filter through the meeting structure – management meetings, full facility, RAP, clinical meetings. In addition to general discussion about the objectives, the various meetings also discuss progress towards the Quality Improvement Plans (QIPs). In the case of Rowena Jackson these two processes are generally linked. The following focus on the resident and clinical QIPs and provide two examples that demonstrate the facility is proactive in using the QIP process to improve outcomes for residents.</p> <p>a) Maintaining a restraint free environment. The service has been restraint free for over six years. This has been achieved by the implementation of a system of 'intentional rounding' where staff provide a greater degree of supervision and monitoring of residents who are at risk of falls and who have challenging behaviours. Restraint meetings are held in April and October and restraint, falls management and behaviours are also discussed at monthly clinical meetings. Education for staff has been provided on three occasions in 2014 as well as challenging behaviour management and de-escalation techniques. Discussions with residents and families occurs where restraint has been suggested by family members. Alternatives to restraint are discussed and plans are in place for alternatives to restraint. Monthly analysis of</p>
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			<p>falls and challenging behaviours is discussed at monthly RAP meetings and full facility meetings. An audit of restraint in August 2014 achieved a 100% compliance rate. Staff interviewed were knowledgeable regarding the maintenance of a restraint free environment.</p> <p>b) Health and safety programme. Promotion of a safe working environment had been a focus for 2014 with achievement of ACC partnership programme award for two years in a row. The village manager has gained stage three health and safety qualifications and the health and safety officer has gained stage one. Health and safety meetings are held monthly with discussion of hazards and the hazard register part of the full facility meeting and RAP meetings. A health and safety bulletin is produced monthly and this is posted on staff notice boards. Education and actions around safe manual handling and back care to reduce staff injuries has occurred in 2014. Training has also been provided around use of lifting equipment and slide sheets. New staff receive training on back care and safe manual handling with education provided by staff and physiotherapist. A specific manual handling induction package is provided for new staff and this includes theory and practical sessions. Monthly trend analysis of staff incidents has been conducted. A reduction in reported staff injuries is noted for the latter six months of 2014. Staff interviewed were well versed in health and safety, hazard identification, and back care. New staff confirmed that safe manual handling training had been provided as part of induction.</p> <p>Full review of all facility QIP's has been conducted in December 2014. As a team, Ryman Rowena Jackson are responsive to staff, resident and relative feedback and take a quality cycle</p>
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			approach to improving resident outcomes.
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End of the report.