# Beckenham Courts 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Essie Summers Retirement Village Limited

**Premises audited:** Essie Summers 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: 18 May 2015 End date: 19 May 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:** 93

# 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 |
|  | 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

Essie Summers Village is a Ryman Healthcare facility. The facility provides rest home, hospital and dementia level of care for up to 125 residents. On the day of audit there were 93 residents.

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, management and staff

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

The service has been awarded three continuous improvement (CI) ratings around good practice and implementation of the quality and risk management programme.

## 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. |

Essie Summers provides 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 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 accommodate the choices of residents and/or their family. Informed consent is sought and advanced directives were appropriately recorded. Complaint processes were being implemented and documented. Residents and family interviewed verified on-going 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. |

Essie Summers is implementing the Ryman Accreditation Programme that provides the framework for quality and risk management. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey has been completed and regular resident/relative meetings have been held. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Essie Summers collects and analyses clinical indicator data across the three services being provided (hospital, rest home and dementia care). 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 was supported. The organisational staffing policy aligns with contractual requirements and included 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. |  | Standards applicable to this service fully attained. |

There is comprehensive service information available. On admission, registered nurses complete initial assessments and risk assessment tools. Care plans and evaluations reviewed, had been completed by the registered nurses within the required timeframe. Care plans reviewed demonstrated service integration, were individualised and evaluated six monthly. Assessment tools and monitoring forms were completed and updated on the Vcare on-line system. Care plans were available for care staff. The residents and family interviewed confirmed they were involved in the care planning and review process. Short term care plans were in use for changes in health status. The activity coordinators provide a separate activities programme for the residents in the rest home, hospital and special care unit. The activity programme ensures the individual abilities and recreational needs of the resident are met. It was varied, interesting and involves the families and community. There were policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are one-three monthly GP medication reviews. Meals are prepared on site. A dietitian at an organisational level designs the menu. Individual and special dietary needs are catered for. Alternative options are provided. Residents interviewed responded favourably to the meals 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 resident rooms are single and have en-suites. There is sufficient space to allow 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. Housekeeping staff maintain a clean and tidy environment. All laundry and linen is 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 maintains a restraint free environment. Restraint use is reviewed by the restraint approval committee. Staff have been 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

The infection control programme is appropriate for the size and complexity of the service. The infection control co-ordinator (clinical manager) and infection control officer (RN) are responsible for coordinating/providing education and training for staff. The infection control co-ordinator and officer have attended external training. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes 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** | 2 | 43 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 90 | 0 | 0 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures are in place and align with the requirements of the Code of Health and Disability Services Consumer Rights (the code). Families (three hospital, four dementia care unit and one rest home) and residents (five rest home and six hospital) interviewed stated they were provided with information on admission which included the Code. Interview with six care assistants (who work across all areas of the care centre) demonstrated an understanding of the Code. Residents and relatives confirm staff respect privacy, and support residents in making choice where able. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the resident files sampled (three hospital, four rest home- including one respite, and three dementia care). Care assistants and RNs interviewed confirm consent is obtained when delivering care. Resuscitation orders for competent residents were appropriately signed. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident is deemed incompetent to make a decision.  Discussion with family members identifies that the service actively involves them in decisions that affect their relative’s lives. Nine admission agreements sighted were signed within the required timeframe. |
| 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 on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files includes information on residents’ family/whanau and chosen social networks. |
| 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 | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisational complaints policy is being implemented at Essie Summers. The village manager is overall responsible for ensuring all complaints (verbal or written) are fully documented and investigated. Concerns and complaints are discussed at relevant meetings. There were five complaints in the register for 2015. All complaints reviewed in the register were resolved and have been managed appropriately. Discussion with residents and relatives confirmed they were provided with information on the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives reported that information is provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager reported having an open door policy and described discussing the information pack with residents/relatives on admission. 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. |
| 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 privacy and confidentiality. A tour of Essie Summers confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ privacy by knocking on doors prior to entering resident rooms. The service had a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement (11 files reviewed). There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Interview with staff described how choice is incorporated into resident cares. |
| 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 individual and cultural, values and beliefs. | FA | Ryman has a Maori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care 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. At the time of audit the staff reported there were no residents that identify as Maori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out where the resident and/or whanau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, clinical services manager, unit coordinators and registered nurses (RN) confirmed an awareness of professional boundaries. Care assistants interviewed could discuss professional boundaries in respect of gifts. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | All Ryman facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Each unit has staff meetings and resource folders for staff. There are written and verbal handovers between shifts. Staff complete competencies relevant to their role. An annual in-service education programme planned by the Ryman Accreditation programme (RAP) is being implemented at Essie Summers. Registered nurses reported having access to external training. Services are provided at Essie Summers that adhere to the health & disability services standards. A continued improvement rating has been awarded around good practice. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Essie Summers is utilising the electronic reporting of incidents into the Ryman system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There was an interpreter policy and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Essie Summers is a Ryman Healthcare retirement village. The service provides rest home, hospital and dementia level of care for up to 125 residents. This includes 30 serviced apartments that have been certified as suitable to provide rest home level care. There were four rest home residents in the serviced apartments.  There were 93 residents in the facility on the day of audit including 36 rest home, 33 hospital level residents, and 24 dementia care residents. There are 71 hospital and rest home rooms that are dual purpose.  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.  Essie Summers objectives for 2015 include; (i) continuation of the falls reduction programme into the hospital unit (successfully implemented in the rest home and commenced in the special care unit); (ii) improving resident, relative and staff relationships and communication; (iii) focus on staff health and wellbeing; (iv) recruit, retain and train staff; (v) maintain low urinary tract continuous improvement; and (vi) improve the dining experience of the residents.  The village manager (RN) at Essie Summers has been in the role for eight years and is supported by an assistant manager/health and safety officer who has been in the role for six months. The clinical manager/RN has been in the role for three years and is supported by RN unit coordinators. The facility management team are supported by a regional manager and clinical quality auditor (at head office). The village manager has maintained at least eight hours to date of professional development activities related to managing a village. |
| Standard 1.2.2: Service Management  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. | FA | Ryman policy outlines manager availability including on call requirements. During a temporary absence, the assistant manager and clinical manager will cover the manager’s role. The assistant manager covers administrative functions and clinical manager 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. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Essie Summers 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.  Outcomes from the RAP Committee are then reported across the various meetings including the full facility, registered nurse and care assistants. 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). Health and safety and infection control meetings are held two monthly. Clinical meeting minutes were sighted. Interview with staff confirmed an understanding of the quality programme.  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 be completed to maintain competence.  Relative survey was last completed March 2015. The facility rated fifth out of the 27 Ryman villages. Results have been collated. Areas of concern were identified and quality improvement plans raised (QIPs) and completed.  The RAP prescribes the annual internal audit schedule that has been implemented at Essie Summers. Audit summaries and QIPs are completed where a noncompliance is identified (<90%). Issues and outcomes are reported to the appropriate committee e.g. RAP, health and safety. QIP’s reviewed, were seen to have been closed out once resolved.  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 – e.g. falls. Falls reduction strategies were put in place in January 2014 that include (but are not limited to); hi/lo beds, on-going falls assessment and exercises by the physiotherapist and physiotherapy assistant, sensor mats, appropriate footwear, hazard identification and room layout, intentional rounding, completion of monitoring charts, up to date care plans, Vcare generated triggers of reassessment and falls protocols, regular toileting, walk with me programme, AAA exercise programme, traffic light alerts to guide care staff on the residents mobility. The reduction in falls after the introduction of these strategies has put the facility consistently less than the group. The service has a “lounge assistant” in the hospital unit to monitor high falls risk residents.  Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Quality objectives for the 2014 year have been reviewed and 2015 objectives in place. A peer support group has been commenced for residents coming into care and a staff mentoring group to provide support and fellowship for new staff.  There is a health and safety, and risk management programme being implemented at Essie Summers. The combined health and safety and infection control committee met two monthly and included discussion of incidents/accidents and infections. There is a safety representative who has attended training. There is a current hazard register. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Essie Summers collects incident and accident data and completes electronic recording of events. Monthly analysis of incidents by type is undertaken by the service and reported to the various staff meetings. Data links to the organisation's benchmarking programme and used for comparative purposes. In 2014 a QIP was generated to implement a falls reduction strategy. The aims of the strategy were to identify and minimise factors which may increase the risk of residents falling, to increase staff awareness and knowledge for falls risks/management/re-education and to achieve falls rate below the national quality indicator. Incident forms were reviewed from April 2015. QIPs were created when the number of incidents exceeded the benchmark. 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. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | 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 11 staff files reviewed. Performance appraisals are current in all files reviewed. Interview with care assistants and RNs stated management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation.  There is an annual training plan which aligns with the RAP programme that was being implemented. There is an on site aged care education assessor.  Ryman ensures RN’s are supported to maintain their professional competency including attending the journal club meetings and completing InterRAI training through the Ryman programme. A register of current practicing certificates is maintained.  Seven of thirteen care staff who are employed in the dementia care unit have completed their dementia specific units. The remaining six staff have commenced dementia specific units within the required timeframe. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ryman organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a fulltime clinical manager. Each unit in the care centre has a RN Unit coordinator. The serviced apartment coordinator is a senior care assistant. There are 11 registered nurses as well as the management team and unit co-ordinators. There is one registered nurse on duty morning shifts seven days a week in the rest home and special care unit. The hospital unit has two RNs on duty for all morning and afternoon shifts and one on duty for the night shift. The hospital RN oversee the other unit when there is no RN on duty in them. Interviews with care staff informed the registered nurses are supportive and approachable. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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. 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. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. The clinical manager screens all potential residents prior to entry to services to confirm they meet the level of care provided at the facility. Five rest home and six hospital residents and eight relatives interviewed (three hospital, one rest home and four special care) confirmed they received information prior to admission and discussed the admission process and admission agreement with the village manager. Ten admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Transfer information reviewed was completed by the registered nurse or clinical manager and communicated to support new providers or receiving health provider. The information meets the individual needs of the transferred resident. Six RNs interviewed could describe the required transfer documentation including the yellow envelope system used by the district health board. Relatives interviewed confirmed they are kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All medication is managed appropriately in line with required guidelines and legislation. RNs and care staff responsible for the administering of medication complete annual medication competencies and attend annual medication education. The service uses individualised medication blister packs for regular and PRN medications. Medications are checked on delivery against the medication chart. Medication trolley contents were all within expiry dates and all eye drops were dated on opening. There were three self-medicating residents. Medication administration practice was observed to be compliant. As required medications have the date and time of administration on the signing sheet. Twenty medication charts sampled (eight hospital, eight rest home and four dementia care) meet legislative prescribing requirements.  Twenty medication charts reviewed identified three monthly medication reviews signed by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service employs a qualified cook. A cook assistant and kitchen hand supported them each day. A four weekly seasonal menu had been designed and reviewed by a dietitian at an organisational level. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly reviews. Specific cultural preferences are met. There was evidence that there are additional nutritious snacks available over 24 hours. Resident likes, dislikes and dietary preferences were known. There are two meal options identified on the menu for the evening meal. Food is delivered in hot boxes to each area. Staff were observed sitting with the residents when assisting them with meals. The service is well equipped with separate dishwashing area, baking, cooking and storage areas. The freezer temperature is checked weekly. The walk-in chiller is checked daily. Food temperatures are monitored twice daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals were stored safely in the kitchen. Feedback on the service is received from resident and staff meetings, surveys and audits. Residents interviewed spoke positively about the food provided.  Staff have been trained in safe food handling and chemical safety.  There is evidence that there are additional nutritious snacks available over 24 hours. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The manager at every stage will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry is referred back to the Needs Assessors or referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The following personal needs information is gathered during admission (but not limited to): personal and identification and next of kin, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, activities of daily living, equipment needs, family/whanau support, activities preferences, food and nutrition information and mental cognition.  E 4.2 Behaviours assessments and monitoring charts are used for any residents that exhibit challenging behaviours.  Risk assessment tools were sighted as completed on the VCare system and reviewed at least six monthly or when there was a change to a resident’s health condition. Care plans reflected the outcome of the risk assessments for the ten resident files sampled. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Resident/family/whanau involvement in the care planning process was evidenced by signatures on the written acknowledgment of care plan form in the ten resident files sampled. Residents and relatives interviewed confirmed they were involved in their care plans.  Ten files reviewed all included detailed interventions to support the current assessed needs of the residents.  Short term care plans were in use for changes in health status. Examples sighted were for urinary tract infection, chest infection, weight loss, skin tear and rash.  Nine of ten resident files sampled identified that the resident/family were involved in the development/evaluation of care plans.  Two care plans reviewed in the special care unit detail care and support for behaviours that challenge, including triggers, associated risks and management. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. Relatives interviewed stated their relative’s needs were being appropriately met and they were informed of any changes to health and interventions required. Communication was evidenced in the progress notes with a relative contact stamp. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Faxes to the GPs for residents change in health status were sighted in the resident’s files.  Dressing supplies are available and treatment rooms sighted were adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency were entered on the VCare system and linked to the long term care plans. Pressure area cares and interventions were documented in the long-term care plans. The RNs interviewed have access to external wound specialist as required. There were nine wounds listed on the VCare register (including one pressure area ) across all service levels. Wounds were assessed/monitored as planned. Short term care plans were in use for the skin tears. The long-term care plan was reviewed for the resident with a pressure wound included with input from District nurse/Nurse Maude.  Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the three RN's interviewed.  Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts. |
| 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 | A team of activity coordinators (six) implement a separate activity programme for the rest home, hospital and special care unit. The activity programme is delivered Monday to Sunday. The activity co-ordinators are trained to deliver the Triple A exercise programme, which is applicable to the cognitive and physical abilities of the resident group. The activities coordinators have completed training around dementia care. Three activity co-ordinators have commenced diversional therapy papers. All have a current first aid certificates.  Activities were observed. The activity programme includes (but not limited to); musical moments, make and create, memory activities, sensational senses and active games. Resources were available for staff use at any time. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. The service has two vans that can be used for outings.  The resident/family/whanau as appropriate completes a “Life experiences” information sheet. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. Resident meetings were held two monthly and open to families to attend. The residents' activity care plans have de-escalating techniques for residents with behaviour that might challenge.  The activity plans were reviewed at the same time as the clinical care plans in resident files sampled. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The evaluation and care plan review policy require that care plans are reviewed at least six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited on VCare system and in resident files). Short term care plans are utilised and evaluated regularly.  Family are invited to attend the multidisciplinary review (MDR) meetings. The physiotherapist, GP, activity co-ordinator and care staff are involved in MDR meetings.  Care plans reviewed were evaluated six monthly or more frequently when clinically indicated.  Nine of ten initial care plans reviewed had been reviewed within three weeks of admission. One resident was on respite care. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There is a referral policy. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RN's interviewed stated they initiate referrals to nurse specialist services. Specialist referrals are made by the GP. Referrals and options for care have been discussed with the family as evidenced in interviews and medical notes. Referrals sighted on the resident files sampled were as follows: physiotherapy, needs assessor, dietitian, geriatrician, hospice, community occupational therapist, cardiologist, respiratory medicine and radiology.  Discussions with registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists.  The service provided examples of where a residents condition had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in 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. Safety data sheets were available. Relevant staff have attended chemical safety training. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness which expires on 1 July 2015. The service is divided into three units - each unit on a different level. There is a nurse’s station within each unit.  The temporary maintenance person addresses daily maintenance requests. The service was in the process of recruiting a full time maintenance person at the time of the audit. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of electric beds and hoists. Hot water temperatures in resident areas are monitored and stable between 43-45 degrees Celsius. Contractors are available 24/7 for essential services.  The facility has wide corridors and staircases with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in each unit for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas.  Residents are able to access the outdoor gardens and courtyards safely. Seating and shade is provided. There is an outdoor designated smoking area.  The five care assistants and six registered nurses interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans including the following equipment; sensor mats, electric beds, ultra-low beds, standing and lifting hoists, hospital level lounge chairs, mobility aids, transferring equipment, wheel-on and chair scales and pressure relieving mattresses and cushions.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities.  There are quiet, low stimulus areas that provide privacy when required.  E3.4.c: There is a safe and secure outside area that is easy to access. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | All resident rooms in each area have ensuites. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed (six hospital and five rest home) confirmed their privacy was assured when staff were undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | 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 are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each unit has a lounge and dining area. There are seating alcoves and family rooms available for quiet private time or visitors. The communal areas are easily and safely accessible for residents. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The Ryman group has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits have been 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 for the laundry. Material safety data sheets and personal protective clothing is readily accessible.  There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. The service has purchased a labelling machine, which has greatly reduced the amount of missing clothing. 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. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. There is an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. Emergency lighting is in place for four hours. There are one civil defence kit in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. The service utilises security cameras and an intercom system. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight. |
| Standard 3.1: Infection control management  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. | FA | 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 co-ordinator/officer job description. The infection control programme links to the quality management system via the RAP. The infection control committee meeting is combined with the health and safety committee, which meets two monthly. The facility meetings also include a discussion of infection control matters. The IC programme is reviewed annually from head office and 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 is made up of a cross section of staff from areas of the service including; (but not limited to) the village manager, the clinical manager (who is the IC co-ordinator); infection control officer (RN, hospital co-ordinator) and assistant manager/health and safety officer. The facility also had access to an infection control nurse specialist, population health, GP's and expertise within the organisation and access to district health board (DHB) infection control team. The infection control coordinator and officer have attended external infection control 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 reflect 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  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control co-ordinator and officer have appropriate training and are responsible for coordinating/providing education and training to staff. The induction package includes specific training around hand washing and standard precautions and training was provided both at orientation and as part of the annual training schedule. Resident education is expected to occur as part of providing daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections were in place appropriate to the complexity of service provided. Infections were included on a register and a monthly report was completed by the infection control officer. Monthly data was reported to the combined infection control and health and safety meetings. Staff are informed on infection control matter, 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 used the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. The service had an outbreak in January 2015, which was reported to Population health. An infection control specialist visited the facility and completed debrief meeting and education following the outbreak. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint policy in place that states the organisations 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 and endeavours to be restraint free. On the day of audit there were no residents using restraint or enablers. |

# 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.

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| --- |
| No data to display |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Ryman has a robust quality and risk supporting structure that is implemented at Essie Summers. The Ryman Accreditation Programme (RAP) contains standardised policies and procedures, a benchmarking programme which benchmarks against similar service types within the organisation, an internal audit and corrective action planning process, an education programme which includes core competencies for the various staff groups, the centralised management of complaints and internal investigation following sentinel incidents and resident, relative and staff surveys are conducted. There is a meeting schedule which is evidenced adhered to | Ryman staff complete education competency assessments for infection control, nursing care assessments, fire training, manual handling, and health and safety and these competencies are specific to each role. Essie Summers competencies are up to date. The Educator maintains data entry into a specific computer software programme (Qualification and Education) to ensure that all information is current. Essie Summers supports staff to attend external as well as internal training sessions. Clinical Managers attend study days three monthly which are held in Christchurch. The village manager and clinical manager attends an annual Ryman three day conference. Group Conference calls between the Regional Manager (RN) and nursing staff were evidenced to have occurred to discuss the implementation on the new infection control policies released in February 2015. The education summary contained evidence of peer review, discussion and debate. Five registered nurses have attended InterRAI training and RNs are allocated one day per month where they are super-numerary to the roster to enable them to conduct the required number of InterRAI assessments to maintain their competency. There is a bimonthly journal club which provides an education opportunity for registered nurses and the forum for peer review and self-reflective activities. Both care giving and nursing staff have attended “walking in another’s shoes” education at Princess Margaret Hospital which provides an insight into Dementia and how staff can help residents and families deal with the challenges that the disease process has on the resident their family and their carers.  The Ryman Internal Audit programme schedules the required audits which are to be completed each month. Where the audit result identifies a result of less than 90% compliance a Quality Improvement Plan is initiated. A review of Internal audits conducted in 2014-2015 evidence that QIPs have been developed and closed out when the goal has been achieved and sustained. All staff are involved in the Quality Improvement Programme and internal audits are allocated to staff to complete to ensure the integrity of the results and a full understanding of the Quality Cycle. Clinical file reviews are part of the Internal auditing process.  Services are benchmarked against similar service types within the organisation. Areas benchmarked include falls, falls with fractures, skin tears, urinary tract infections, respiratory tract infections, pressure ulcers, medication errors, restraint and enablers and unintentional weight loss. In 2014, a QIP was generated to implement a falls reduction strategy. The aims of the strategy were to identify and minimise factors which may increase the risk of residents falling, to increase staff awareness and knowledge for falls risks/management/ re-education and to achieve falls rate below the national quality indicator. Incident forms were reviewed from April 2015. QIPs were created when the number of incidents exceeded the benchmark. QIPs were seen to have been actioned and closed out . It was identified through the benchmarking that the facility was in the higher percentiles against the other Ryman village for UTI rates despite doing everything the other villages did in trying to reduce rates with preventative measures the rates continued to climb so a new strategy was developed. After consultation with a senior microbiologist in 2014 a new strategy was formulated and implemented. The rest home has maintained the lowest UTI rates for all Ryman facilities and in the last six months had three UTI free months. The UTI’s that do occur are in residents with indwelling urinary catheters, to manage this care staff have completed hygiene training to prevent cross contamination. Other Ryman facilities are now adopting this strategy following the success of Essie Summers reducing UTI’s from being the worst performing to the bestMeetings are held regularly and minutes reviewed evidence discussion about key aspects of care delivery and resulting trends from benchmarking. Graphs and meeting minutes are available in the staff rooms in each area. Any matters outstanding are evidenced to have been followed through to the next meeting |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | CI | 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. Service specific objectives are reviewed as prescribed in the RAP.  Essie Summers had falls minimisation quality objectives set in 2014. The 2015 goals are set to continue this programme into the hospital and special care unit. The QIP process has been used to plan and evaluate progress towards this objective. Progress towards objectives was seen to have been discussed at the various staff meetings. | Essie Summers had identified a quality improvement objective in the 2014 year to reduce the falls rate within the rest home. The facility established a falls action group which met monthly and discussed: falls incidence, trend analysis, roster review in regard to times of falls, GP review of medications as appropriate.  Staff education was put in place which included implementing “intentional rounding” whereby residents were checked either ½, one or two hourly depending on their falls risk rating. This rounding was documented on a monitoring chart and pre-empted the resident trying to walk alone. The walk with me programme was also taught to the staff and implemented, this involved staff taking a resident with them when they went to get something thereby increasing the frequency of walks and adding a normal activity to the residents’ day (e.g. getting milk from the kitchenette). Regular toileting is undertaken and residents are encouraged and assisted to attend the Triple A exercise programme.  The physiotherapist – who was actively involved in the project – developed a ‘traffic light’ concept with staff that described at a glance how to safely transfer a resident – i.e. Green meant the resident was independent with transfers, orange meant the resident required one staff member to assist, and red two person assist. The traffic lights were kept in each resident wardrobe (sighted). The physiotherapist assesses all residents on admission and following a fall. A physio plan is formulated to include walking, exercises and strengthening which is undertaken by the physiotherapist, physiotherapy assistant or care staff.  Staff interviewed reported they are made fully aware in handover of residents who are at risk of falling and the strategies in place to prevent this. They have all completed manual handling. Care plans are all kept up to date and risk assessments re-done following falls. The Vcare kiosk triggers reassessments and the activation of falls protocols when an incident form is completed, and a GP referral after two falls.  This continuous improvement has been awarded based on the results achieved against the organisation targets. The falls rates in the rest home remain continuously below the group with two of the last six months having no falls. The special care unit and hospital unit that were opened in 2014 have adopted the programme and have each maintained falls below the group since opening except for one month each. |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | Infections were included on a register and a monthly report was completed by the infection control officer. Monthly data was reported to the combined infection control and health and safety meetings. Staff are informed on infection control matter, 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 used the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. | It was identified through the benchmarking that the facility was in the higher percentiles against the other Ryman village for UTI rates despite doing everything the other villages did in trying to reduce rates with preventative measures the rates continued to climb so a new strategy was developed. After consultation with a senior microbiologist in 2014, a new strategy was formulated and implemented. (i)The key focus of this strategy is yoghurt therapy which is offered and encouraged to the residents at all meals. Pottles, yoghurt drinks, yoghurt ice cream and other forms were provided to suit individual tastes. (ii)Increasing fluids by providing flavoured and colourful drinks at mealtimes, offering jelly after a meal, “mocktails”, ice blocks at random times and cold drinks at morning and afternoon tea time. (iii) Fluid balances are maintained accurately, regular toileting undertaken and residents are provided with cups and equipment they can manage, (iv) the strategy and in particular the yoghurt therapy was discussed at all staff, relative and resident meetings. The strategy has now become the culture of the facility and was implemented in the special care and hospital units when they opened following the success in the rest home. The rest home has maintained the lowest UTI rates for all Ryman facilities and in the last six months had three UTI free months. The UTI’s that do occur are in residents with indwelling urinary catheters, to manage this care staff have completed hygiene training to prevent cross contamination. Other Ryman facilities are now adopting this strategy following the success of Essie Summers reducing UTI’s from being the worst performing to the best. |

End of the report.