# Jean Sandel 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:** Jean Sandel Retirement Village Limited

**Premises audited:** Jean Sandel 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: 12 October 2015 End date: 13 October 2015

**Proposed changes to current services (if any):** This audit has approved the change of a family room to a temporary hospital room increasing the hospital capacity from 50 to 51.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 111

# 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

Jean Sandel is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 112 residents. On the days of the audit, there were 111 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit also reviewed the reconfiguration of a family room on an intermittent basis to a temporary hospital bed. The 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.

Jean Sandel is managed by a village manager/registered nurse who is appropriately qualified and experienced. An assistant village manager, a clinical manager, unit coordinators, and a regional manager support the village manager. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

The residents and relatives interviewed spoke positively about the care and support provided.

The service has been awarded two continuous improvement ratings around activities and the food service.

## 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. |

Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori Health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and where appropriate their families, are involved in care decisions. Informed consent and advance directives are in place. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets timeframes established by the HDC.

## 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. |

Jean Sandel implements the Ryman Accreditation Programme that provides the framework for quality and risk management. Key components of the quality management system are linked to a number of meetings, including staff meetings. Regular resident/relative satisfaction surveys are completed and there were regular resident/relative meetings. Quality and risk performance was reported across the various facility meetings and to the organisation's management team.

Jean Sandel provided clinical indicator data for the three services being delivered (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 has been supported. The organisational staffing policy aligns with contractual requirements and included skill mixes. Registered nursing cover is provided 24-hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents’ files are appropriate to the service type.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Residents and families receive a comprehensive admission package outlining the services available at Jean Sandel. The service has a well-developed assessment process and residents’ needs are assessed prior to entry. The registered nurses complete assessments, care plans and evaluations. Care plans are reviewed and updated six monthly or more frequently when clinically indicated. Residents/relatives are involved in planning and evaluating care. Care plans demonstrate service integration. The service facilitates access to other medical and non-medical services.

The Engage activities programme has been fully implemented and provides activities that encourage resident participation and socialisation including community links. Each resident has an individualised activity plan.

Medication policies and procedures are in place to guide practice. All staff responsible for administration of medicines completed education and medication competencies. The medication charts reviewed included documentation of allergies, photo identification and general practitioner reviews at least three monthly.

Meals are prepared on site, individual and special dietary needs are catered for. Nutritious snacks are available 24 hours in the dementia care unit. Residents interviewed responded favourably about the food provided.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

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

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager/restraint officer oversees restraint/enabler usage within the facility. The service currently has one resident using a restraint and no residents using enablers. A register for restraints is maintained. Review of restraint use is reviewed by the restraint approval committee six monthly. Staff are trained in restraint minimisation.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme is appropriate for the size and complexity of the service and includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six monthly comparative summary is completed. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service has successfully managed to contain two outbreaks of norovirus since the last audit.

## 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 | 48 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 99 | 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 being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents were provided with information on admission, which included the Code. Staff received training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interview with seven care assistants (three rest home, two dementia and two hospital) demonstrated an understanding of the Code. Residents interviewed (five rest home and five hospital) and relatives (two rest home, two hospital and one dementia) 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 consents are signed by the resident or their EPOA, as part of the admission process. Advanced directives/resuscitation orders are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed (RNs) confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  Eleven of eleven resident files sampled had a signed admission agreement. |
| 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 included information on residents’ family/whānau 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. Residents were assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Interviews with staff, residents and relatives informed that 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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  A complaints register includes written and verbal complaints, dates and actions taken. Complaints have been managed within in a timely manner, meeting Health and Disability Commissioner (HDC) timeframes. Eight complaints have been lodged in 2015 (year to date). There is evidence of complaints received being discussed in staff and management meetings. All complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction. |
| 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 interviewed advised that information had been provided around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The unit coordinators or clinical manager would discuss the information pack with residents/relatives on admission. |
| 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 | A tour of Jean Sandel confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents’ privacy. Staff could describe definitions around abuse and neglect that align with the Ryman policy. Residents and relatives interviewed confirmed that staff treat residents with respect.  The service has a philosophy that promoted quality of life and involved residents in decisions about their care. Resident preferences were identified during the admission and care planning process, with family involvement noted in the eleven files reviewed (four rest home, four hospital, and three dementia). There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.  Interview with caregivers 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 Māori 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/whānau 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 identified as Māori. |
| 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 whānau 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 informed 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. 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 managers, registered nurses and caregivers confirmed an awareness of professional boundaries. Caregivers could discuss professional boundaries in respect of gifts. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.  A range of clinical indicator data is collected against each of the service levels. The data is reported through to head office for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman Accreditation Programme (RAP). Quality Improvement Plans (QIP) are developed where results do not meet expectations. Ryman have an electronic patient system used by all sites to report relevant data through to head office. The system of data analysis and trend reporting is designed to inform staff at facility level. Management at facility level are then able to implement changes to practice, based on the evidence provided.  Jean Sandel has implemented a number of process improvements in service delivery resulting in improvements to resident wellbeing. Quality improvements have been made in the reduction of falls.  Staff are required to read the organisational policies and to regularly complete staff comprehension quizzes based on the content of the organisational polices. Education is regularly provided to all staff on a range of topics related to aged care. Education is supported for all staff and a number of staff hold National certificate qualifications. Registered nurses regularly access training, including sessions that are externally run.  Discussions with the residents and relatives were very positive about the care they receive. All services provided at Jean Sandel adhere to the health and disability services standards. There are implemented competencies for caregivers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.  As a result of feedback from the February resident satisfaction survey, a quality improvement plan was developed to improve communication with the residents. This included the introduction of residents’ monthly feedback forms across all areas of the business. The feedback forms were discussed at the weekly management meetings. Prompt communication with residents and or the families about their issues then occurred. The effectiveness of the QIP was evaluated which identified an improvement in the number of complaints over the same period the previous year. |
| 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. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Jean Sandel is a Ryman healthcare retirement village providing rest home, hospital and dementia level care for up to 112 residents. This includes 39 rest home level beds, 51 dual-purpose beds, and 22 dementia level beds. The service also has 20 serviced apartments certified as able to provide rest home level care. There were no residents receiving rest home care in the serviced apartments on the day of audit. Occupancy during the audit was 55 rest home level residents (including 16 in the dual-purpose beds), 34 hospital level residents and 22 dementia level residents. The service holds the Aged Related Residential Care (ARRC) contract, respite contract and the Long-Term Chronic Conditions (LTCC) contract. There was only one rest home level resident on respite care during the audit and none on the LTCC contract. Jean Sandel is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care. The additional hospital dual-purpose beds have been assessed as suitable as part of this audit with a new total of 51 dual-purpose beds available.  There is a documented service philosophy developed at head office that guides quality improvement and risk management in the service. Specific values have been determined for the facility. Organisational objectives for 2015 are defined with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2015 objectives.  The village manager at Jean Sandel has been in the role since August 2015 and has a background in facility and regional management in aged care. An assistant manager, who carries out administrative functions and a clinical manager (registered nurse) who oversees clinical care, support the village manager. The wider Ryman management team that included a regional manager supports the management team. The village manager and clinical services manager have maintained at least eight hours 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 | On the days of the audit, the village manager was on annual leave. During the village manager’s temporary absence, the assistant manager and clinical manager cover the village manager’s role. The regional manager provides oversight and support. |
| 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 | Jean Sandel has a well-established quality and risk management system directed by head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the managers (regional manager, assistant village manager, clinical manager/RN, unit coordinators) and staff (seven care givers, five registered nurses, one laundry, two cleaners, one chef, one maintenance staff, two activity coordinators and one diversional therapist) and review of management and staff meeting minutes, demonstrate their involvement in quality and risk activities.  Resident meetings are held two-monthly in the rest home and in the hospital. Relative meetings are held six-monthly. Minutes are maintained. Resident and relative surveys are completed annually. Results show satisfaction with the service. Action plans were completed with evidence that suggestions and concerns are addressed.  The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level, in accordance with the monthly Ryman accreditation programme (RAP) calendar. They are communicated to staff, evidenced in staff meeting minutes. Recent updates to policies and procedures include procedures around the implementation of InterRAI.  The quality-monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.  The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.  Health and safety policies are implemented and monitored at the two-monthly health and safety committee meeting and it also includes review of infection control and of incidents. A health and safety officer is appointed who has completed stage two health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice to March 2016. The hazard identification resolution plan is sent to head office and identifies any key hazards that are identified. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified. |
| 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 | There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.  A review of 14 incident/accident forms for the facility identifies that all are fully completed and include follow-up by a registered nurse. The managers are involved in the adverse event process with regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.  The clinical manager is able to identify that appropriate situations would be reported to statutory authorities. There is evidence that the Ministry of Health and the district health board were kept informed following two recent norovirus outbreaks. |
| 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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed included a signed contract, job description relevant to the role the staff member is in, police checks, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.  A register of registered nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.  A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. The programme is tailored specifically to each position. The time allocated for orientation/induction training has increased to five days.  There is an implemented annual education plan. The annual training programme exceeds eight hours annually. Registered nurses are supported to maintain their professional competency. All registered nurses have completed or are completing their InterRAI training, meeting contractual requirements. Staff training records are maintained. There are specific competencies for registered nurses and caregivers related to their role. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills-mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. There are registered nurses on duty 24 hours per day.  Staff on the floor on the days of the audit were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers. |
| 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 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, secure and cannot be viewed by other residents or members of the public. Care plans and notes were legible and where necessary signed (and dated) by a registered nurse. Entries reviewed were legible, dated and signed by the relevant caregiver 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 pack outlining services provided, the admission process and entry to the service. All potential residents have a needs assessment completed prior to entry. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement aligns with the requirements of the ARC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the receiving provider. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were 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 | Medicine management meets the legislative requirements. RNs, enrolled nurses and caregivers responsible for administering medication complete annual medication competencies and attend annual medication education. Medications are checked on delivery against the medication chart. Medications contents were all within expiry dates and all eye drops were dated on opening. There were three self-medicating residents in the rest home with completed self-medication assessments which had been reviewed by the GP three-monthly. Standing orders are not in use. Medication administration practice was observed to be compliant. Twenty-two medication charts sampled (eight hospital, eight rest home and six dementia care) met legislative prescribing requirements and had photo identification and allergy status identified.  The GP had reviewed the 22 medications charts at least three monthly. |
| 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. | CI | The service employs a qualified chef to oversee the food services. All staff have been trained in food and chemical safety. A four-weekly seasonal menu also includes a menu for moulied/pureed meals. A dietitian at organisational level reviews the menu. The summer menu due to commence in November 2015, has been reviewed to include two options for the evening meal. Nutritious snacks (including ‘food on the run’ platters), is available 24 hours per day in the dementia unit. Food is delivered in hot boxes to each area’s kitchenette and served from bain maries. The serving temperature in the bain maries are monitored and recorded daily. End cooked food temperatures are monitored twice daily and recorded. Freezer temperatures are recorded monthly with visual displays available. The chiller has visual temperatures and recorded daily. Kitchenette fridge temperatures are checked daily and recorded. All foods (including decanted goods) were date labelled.  Feedback on the service is received from resident and staff meetings, surveys and audits. |
| 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 service records the reason for declining service entry to residents, should this occur and communicates this decision to residents/family. Any potential residents declined entry is referred back to the 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 | Information gathered on admission from discharge summaries, referral letters, medical notes, and from discussion with the resident/family, is used to develop the initial assessment care plan and the first InterRAI assessment/resident long-term care plan. Risk assessment tools are available for use on admission and reviewed six monthly or if the resident’s health status changes. The outcomes of assessments were reflected in the care plans reviewed. All new admissions since 1 July 2015 have had InterRAI assessments completed within three weeks of admission. Over 50% of the facility residents have had an InterRAI assessment completed. The remaining residents are scheduled to have InterRAI assessments completed as their review falls due. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | An initial support plan is completed within 24 hours in consultation with the resident (as appropriate) and relative. The long-term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. One respite care resident had an initial assessment and care plan in place that reflected the resident’s current needs. Outcomes of risk assessments were reflected in the care plans. Resident/family involvement in the care planning process was evidenced by signatures on the written acknowledgment of care plan form in the resident files sampled. Residents and relatives interviewed confirmed they were involved in their care plans. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and input from allied health professionals.  Behaviour management plans were sighted in the three dementia-care resident files sampled. The plans were individualised and included triggers for identified behaviours, interventions and activities over the 24-hour period.  Short-term care plans are used for residents with infections and long-term care plans are updated for other short-term needs. |
| 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. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultation.  Dressing supplies are available and treatment rooms adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency for skin tears (three rest home, two hospital and zero dementia care unit) and seven chronic/ongoing wounds (two hospital, four rest home and one dementia care), were entered on the electronic software system. There were no current pressure injuries. Residents identified as high risk of pressure injuries had interventions documented in the long-term care plan. The RNs interviewed could describe the referral procedure to access wound nurse or continence nurse specialist as required.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. |
| 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. | CI | There is a team of 10 activity coordinators across the rest home, hospital and dementia care unit. The rest home and hospital programme is Monday to Friday. The activities in the rest home and hospital are open to all residents including dementia care residents under supervision. Volunteers visit weekly to spend one on one time with residents who are unable or choose not to participate in the activity programme. The activity programme in the dementia unit is seven days a week, with a lounge-carer in attendance from 4 pm – 8.30 pm assisting with activities and meals.  On the day of audit, residents were actively (and passively) involved in a variety of activities in the rest home, hospital and dementia care unit. Increased attendance at activities has had a positive effect on reducing the number of challenging behaviour incidents, for which the service has been awarded a continuous improvement rating.  Residents have an activities/social profile assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, community links and family. This is used to develop a resident centred activity care plan, which is reviewed and evaluated six monthly at the same time as the care plan.  Community links include outings, fortnightly combined churches, Sunday communion, weekly entertainers, visiting speakers, inter-home visits and card groups.  Residents and relative meetings provide feedback around the activity programme. A monthly activity report to families keeps them informed of upcoming events. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident files reviewed demonstrated that care plans are evaluated by the registered nurses six monthly or when changes to care occur. Written evaluations reviewed document progress to meeting desired goals and if met or unmet. Long-term care plans are required to be updated as changes to health/care occur.  There is at least a three monthly review by the medical practitioner in all resident files reviewed.  There are short-term care plans to focus on residents with an infection. Long-term care plans were updated for other residents with short-term needs. These are evaluated regularly and resolved when infection has healed. |
| 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 | Discussions with the registered nurses (RN) identified that the service has access to external and specialist providers. The service facilitates access to other medical and non-medical services. Referral documentation was maintained on resident files reviewed. The service was able to provide evidence of needs re-assessments when the level of care had changed. |
| 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, including general and medical waste. Staff interviewed were aware of practices and processes outlined in the relevant policy. Gloves, aprons and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets were sighted in areas where chemicals were in use. |
| 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 that expires 24 January 2016. The full-time maintenance manager is responsible for reactive and planned maintenance for the care centre. Daily maintenance requests are addressed and signed off (sighted). The maintenance manager is available on call and contractors are available 24/7 for essential services. Electrical equipment has been tested and tagged. Hot water temperatures are monitored and recorded three monthly. Hot water temperature recordings sighted were below 45 degrees Celsius.  The service is divided into three units on two levels (rest home, hospital and dementia care unit). The family room in the hospital can be converted into a temporary bedroom as required for the use of palliative care/respite care for village residents. The bedroom viewed on the day of audit is considered suitable for rest home/hospital level of care and increases the number of dual-purpose beds in the hospital unit from 50 to 51. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space around the facility for storage of hoists and mobility equipment.  The grounds and gardens are landscaped and well maintained. There is safe access to the outdoor gardens and courtyards on the ground level. Hospital level residents are supervised and regularly access the outdoor areas where seating and shade is provided. A designated outdoor smoking area is available for a resident who smokes.  The dementia unit has a safe outdoor courtyard that can be easily accessed. The outdoor area has raised gardens, seating and shade available. There is sufficient space for residents to safely-wander freely indoors and outdoors. There are lounges and seating alcoves for low stimulus activities or visitors. The main lounge is designed so that space and seating arrangements provide for individual and small group activities. |
| 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 | There are adequate numbers of communal toilets near the communal area. All resident rooms have ensuites with toilet and shower facilities. The additional temporary dual-purpose room in the hospital unit is closely located to a communal toilet. The use of a shower room will be designated on occupancy. Toilets have privacy locks. Residents interviewed 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 have been 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 | The rest home and hospital units have a kitchenette, dining area, lounge and library 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 was sufficient space within the dementia units to permit freedom of movement while promoting the safety of residents who are likely to wander. There is an open plan dining and lounge area with an additional lounge (therapy lounge) for residents and families to use at any time. The kitchenette area is safe with locked cupboards for chemicals and a hot water urn. |
| 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 | Ryman has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits were completed as per the RAP programme. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals. The laundry and cleaning areas have hand-washing facilities.  There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered onsite. Cleaning trolleys are stored in secure areas when not in use. 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 have been included in the mandatory in-service programme. Jean Sandel has an approved fire evacuation plan and fire drills have occurred six monthly. There is a staff member on duty at all times with a current first aid certificate. There are 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 three civil defence kits in the facility and stored water. Call bells are in residents’ 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. There is thermostatically controlled underfloor heating throughout the facility. All rooms have external windows with natural sunlight access. All residents interviewed stated they were happy with the temperature of the facility. |
| 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. An infection-control responsibility policy includes chain of responsibility and an infection-control officer job description. The infection control programme is linked into the quality management system via the RAP. The infection control committee is combined with the health and safety committee, which has met bi-monthly. The facility meetings also include a discussion of infection control matters. The infection control programme is reviewed annually at head office and sent out as directed via the RAP annual calendar. The facility had developed links with the GPs, local Laboratory, the infection control and public health departments at the local DHB.  Visitors are requested not to visit if they have been unwell or in contact with any infectious illnesses. Hand sanitiser is appropriately placed throughout the facility. |
| 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 prevention and control committee (combined with the health and safety committee) is made up of a cross section of staff from areas of the service. The infection prevention and control officer has completed online e-learning infection prevention and infection control training. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs and expertise from within the organisation. |
| 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 prevention and control policies that are current and reflect the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and 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 prevention and control officer is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand-washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. |
| 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. | FA | The surveillance programme is organised and promoted via the Ryman accreditation programme calendar. Effective monitoring is the responsibility of the infection prevention and control officer who is a registered nurse. The registered nurse is directly responsible to the clinical manager who reports to the village manager. An individual infection report form is completed for each infection. Data is logged into the electronic system, which gives a monthly infection summary. This summary is then discussed at the bi-monthly combined health and safety and infection prevention and control (IPC) meetings. Three monthly and six monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Jean Sandel include discussion on infection prevention control. The infection prevention programme is incorporated into the internal audit programme. Internal audits are completed for hand washing, housekeeping, linen services, and kitchen hygiene. Infection rates are benchmarked across the organisation.  There have been two outbreaks of infection since the previous audit, one in the serviced apartments and one in the rest home. The outbreaks were well managed according to the MOH guidelines for the management of outbreaks and all reporting requirements were met. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | A restraint policy is 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. An increased use of sensory techniques, activities and intentional rounding has reduced the need for restraint. On the day of audit, there was one resident with restraint (compared to six residents two years ago) and no residents with enablers. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The clinical services manager is the restraint officer for the facility and defined responsibilities are included in the job description. The restraint approval committee meet six monthly and comprise of the restraint officer, rest home coordinator, village manager, GP and activity coordinators. There is education including restraint minimisation and challenging behaviours during induction and ongoing. A dementia care specialist has provided education. Quality and clinical meetings include discussion on restraint. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint officer /registered nurses, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which has been completed for the one resident requiring an approved restraint (bedrails) for safety. Ongoing consultation with the resident and family/whānau was also identified with the consent form signed by the relative and GP. Assessments consider the requirements as listed in Criterion 2.2.2.1 (a) - (h). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint officer is responsible for ensuring all restraint documentation is completed. Episodes of restraint are monitored at pre-determined intervals, depending on individual risk to the resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation considers the areas identified in 2.2.4.1 (a) – (k). Evaluations occur six monthly (or earlier as required) as part of the ongoing reassessment for residents on the restraint register, and as part of their care plan review. Families are included, where possible, as part of this review. Restraint use is reviewed as part of the three monthly GP review. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage throughout the Ryman organisation is monitored regularly. The review of restraint use is discussed at the approval group meetings and relevant facility meetings. The organisation and facility are proactive in minimising restraint. A comprehensive restraint education and training programme includes restraint competencies. Internal restraint audits are completed as part of the internal audit programme. |

# 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | CI | The chef receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly reviews and at other times such as a resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are known. Alternative foods are offered. Special diets such as gluten free and vegetarian are accommodated. A relative survey identified an improvement required around the repetitive nature of pureed meals. | The clinical manager and hospital coordinator observed the evening meal service over a two-week period and noted that residents receiving pureed/moulied meals were not eating their main meal. Staff were supplementing the residents with Complan puddings, ice-cream and custard available on the unit. There were twelve residents requiring a pureed/moulied diet. Discussion and consultation with caregivers further identified ways to improve the evening dining experience and dietary intake for the most vulnerable residents at risk of weight loss. The chef was also involved in the review of the pureed/moulied evening meals and the menu was changed to focus on a lighter option of egg, fish and chicken meals with white sauces and alternate carbohydrates and sweet potato. An evening dessert option was also introduced for these residents. The team had also researched dining and eating habits for residents with dementia and introduced red plates that are lipped for easier eating and smaller for small and attractive servings. White tablecloths were purchased to assist the residents to see the contrast between the white tablecloth and red plates. The residents were observed by caregivers to be enjoying the changes to the texture modified meals and the changes were made to the menu in March 2015. Relative feedback has been positive. Ten of the remaining residents on pureed/moulied meals (two have deceased) have increased weight over the six-month period from March 2015 to October 2015. Results range from an increase of 0.2% – 8.8%. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The Ryman engage programme was implemented in September 2014 with new and varied activities. The engage programme incorporates 10 core programmes which are musical moments, memory lane, poet’s corner and book corner, make and create, men’s club, mind benders, sensational senses, village friends and Triple A. The key objectives of the engage programme have been evaluated over the past year, and the service has increased resident attendance at activities and increased satisfaction in the programme and there has been a decrease in challenging incidents across all areas of the care centre. | 1) The engage programme was implemented for a two week trial in June 2014. Feedback gathered from residents and staff felt the programme could be better developed to meet the needs of the residents at Jean Sandel. A “Think Tank” group was formed and the programme specifically amended for the residents at Jean Sandel that included more opportunities for residents in all areas to come together and engage in activities or sharing of experiences. More staff became involved with the engage programme and looked for opportunities to engage with residents getting to know them better. New activities include a) Monthly bowling tournament with another local rest home, with each village taking turns to host the tournament. b) Cook’s corner gives residents an opportunity to share recipes and do some cooking, using their own recipes prompting much discussion about their days in the kitchen cooking for the family. c) Active games (including chair bowls and giant ball competitions), are well attended with increasing attendance, which meets the physical aspect of the programme. d) Residents are encouraged to attend afternoon teas to share photographs and life experiences. Memory Lane encourages residents to socialise and reminisce on a favourite topic such as a favourite car. Staff take the opportunity to learn about the residents’ previous and current interests. e) Each month a rest home resident invites two other residents to an afternoon tea at a local café. They enjoy the independence and the opportunity to connect with the community and continue with an activity previously enjoyed before coming into care. f) A men’s club was developed with activities that focuses on men, such as Rummikub club, coffee club, sip and share (a beer and game of pool) and create club where men are encouraged to model and build things used by the activities club.  The company lifestyle manager provided education, and ongoing support and resources for the staff and activity team that has contributed to the successful implementation of the engage programme at Jean Sandel care centre. Mini feedback surveys were conducted monthly, which evidenced resident satisfaction with activities. Relative satisfaction surveys completed in October 2014 and March 2015 evidenced an improvement in satisfaction with the activities programme in comparison with previous survey results (sighted). Resident attendance registers have been maintained in the rest home, hospital and dementia care units. Rest home attendance numbers for activities in the month of August 2014 before full implementation of engage was 639 and in September 2015, attendance numbers were 879. Hospital numbers for the month of August 2014 were 939 and in August 2015 were 2,312. Dementia care unit attendance numbers for August 2014 were 1,061 and in May 2015, attendance numbers were 1,317.  2) A lounge-carer position has been recruited for morning and afternoon duties in all areas of the care centre, to assist in activities and one-on-one supervision for residents including those at risk of challenging behaviours. Since the full implementation of the engage programme, there has been a significant decrease in the number of challenging behaviour incidents in all the units. |

End of the report.