# Jane Winstone Retirement Village Limited - Jane Wonstone Retirement Village

## 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:** Jane Winstone Retirement Village Limited

**Premises audited:** Jane Winstone Retirement Village

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 1 December 2015 End date: 2 December 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:** 64

# 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

Jane Winstone is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital and dementia care level care for up to 86 residents. On the days of the audit there were 64 including four residents receiving rest home level of care in serviced apartments. A village manager who is supported by an assistant village manager and a clinical services manager manages the service. The residents and relatives interviewed spoke positively about the care and support provided.

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

Areas of continuous improvements were identified around good practice, the meal service and the laundry 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (eg, the Code) are in place. 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.

Personal privacy and values of residents is 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. Regular contact is maintained with families including 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 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. |

Services are planned, coordinated, and appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

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

There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete assessments, care plans and evaluations within the required timeframe. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes admission visits and reviews the residents at least three monthly.

The activity team provides an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The Engage programme meets the abilities and recreational needs of the groups of residents. The programme is varied and it involves relatives and the community. There were 24-hour activity plans for residents in the dementia care unit that were individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three monthly.

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to 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 occupancy with ensuites. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed 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. |

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service currently has two residents assessed as requiring the use of restraint and one resident using an enabler. The restraint coordinator maintains a register. .

## Infection prevention and control

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

The infection prevention and control programme 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 service has had no outbreaks 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** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 98 | 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 are provided with information on admission, which includes information on the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with seven caregivers who work across each area and all shifts, two registered nurses and one enrolled nurse, demonstrated an understanding of the Code. Nine residents interviewed (five rest home and four hospital residents) and four relatives (one rest home, two hospital and one dementia unit) confirmed that 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. The resident or their enduring power of attorney (EPOA) signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completes a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  Nine files sampled (two dementia, three hospital, three rest home residents in the care centre and one rest home resident in the serviced apartments) have signed admission agreements and consents. |
| 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 include 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. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, such as shopping. There is an onsite shop and hairdresser available. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. 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 are managed in a timely manner meeting timeframes determined by the Health and Disability Commissioner (HDC). Four 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 | An information pack, that includes information about the Code and the nationwide advocacy service is given to prospective residents and families. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information around the Code had been provided to them. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager or the assistant village manager discusses the information pack with residents/relatives on admission. 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 | A tour of the premises 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. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.  The service has a philosophy that promotes quality of life and involved residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.  Interviews with caregivers described how choice is incorporated into resident care provision. |
| 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 plans of residents who identify 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 with the resident and/or whānau as appropriate. 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. Discussions with relatives confirmed that residents’ values and beliefs are considered. Residents interviewed confirmed that staff take into account their cultural 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. 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. | CI | 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 policies 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 are collected against each service level, and reported through to head office for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman Accreditation Programme (RAP). Quality Improvement Plans (QIP) are developed where results do not meet expectations. An electronic patient system is 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.  Jane Winstone identified a declining and low attendance at staff education. As part of their quality improvement plan, they implemented a process to improve attendance at staff education. The programme has resulted in an increased attendance at all staff training. |
| 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 report all incidents and accidents to the registered nurses who then enter details into the electronic system. Staff are required to record family notification when entering an incident into the system. Incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Jane Winstone is a Ryman healthcare retirement village located in Whanganui. Jane Winstone provides rest home, hospital (including medical services) and dementia level care for up to 89 residents. There are 20 serviced apartments certified to be able to provide rest home level care, 39 dual service beds, 10 hospital level beds, and 20 dementia level beds. Occupancy during the audit was 40 rest home level residents (including four in the serviced departments), 9 hospital level residents and 11 residents in the secure dementia unit. The service holds the Aged Related Residential Care (ARRC) contract, and an Intermediate Care contract. There were three residents on respite and two on the intermediate care contract during the audit.  There is a documented service philosophy set 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 Jane Winstone has been in the role since June 2015 and has a background in human resource management. An assistant manager who carries out administrative functions and a clinical services manager (registered nurse) who oversees clinical care support him. The wider Ryman management team that included a regional manager supports the management team. The village manager and the 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 | During a temporary absence, the assistant manager and clinical manager cover the manager’s role.  The assistant manager covers administrative functions and clinical manager clinical care.  The regional manager provides oversight and support.  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 | Jane Winstone 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 (village manager, assistant village manager, clinical services manager/RN), the GP, and staff (seven caregivers, two RNs, one enrolled nurse one health and safety officer, one chef, one diversional therapist, two activity coordinators, one laundry staff, one maintenance staff) and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.  There are two-monthly resident meetings. Relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. An annual resident satisfaction survey was completed in September 2015 and the results showed the overall resident experience was reported as being good or very good by 81% of respondents. Action plans are 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.  Policies are communicated to staff as 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, 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.  The two monthly health and safety committee meetings implement and monitor health and safety policies, which also include review of infection control and of incidents. An appointed health and safety officer 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. The 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 documents any key hazards that are identified. A review of the hazard register and the maintenance register indicates there is resolution of issues identified.  Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Initiatives implemented include routine checks of all residents specific to each resident’s needs (intentional rounding), the use of sensor mats, night-lights, proactive and early general practitioner (GP) involvement, appointing senior healthcare assistants, and increased staff awareness of residents who are at risk of falling. |
| 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 ten incident/accident forms for the facility identifies that all are fully completed and include timely follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week, providing an opportunity to review any incidents as they occur.  The village manager is able to identify significant events that would be reported to statutory authorities. |
| 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. Nine staff files reviewed (three caregivers, two registered nurses, one activities coordinator, one cook, one laundry, and one gardener) included a signed contract, job description, 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’s 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 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. There is an attendance register for each training session and an individual staff member record of training. Evaluations are completed for all training provided. Registered nurses are supported to maintain their professional competency. Four registered nurses have completed their InterRAI training, meeting contractual requirements. Staff competencies are completed as relevant to the 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 is an RN on duty 24 hours.  On the days of audit, staff on duty 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 into the resident’s individual record within 24 hours of entry. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access. Entries are legible, dated and signed by the relevant 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 | There are policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy.  Information gathered on admission is retained in residents’ records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack for residents admitted to the dementia unit contains information relating to the service philosophy, restraint minimisation, behaviour management and the complaints policy.  The admission agreement reviewed aligns with the service’s contracts. Eight admission agreements viewed were signed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with ministry of health medication requirements. An RN completes medication reconciliation on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior care staff who administer medications have been assessed for competency on an annual basis. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided.  Standing orders are not used. One self-medicating resident in the rest home had been assessed by the GP and RN as competent to self-administer.  Sixteen medication charts were reviewed (six rest home, including two residents receiving rest home care in the serviced apartments, six hospital and four dementia). The medication profiles reviewed were legible, up to date and reviewed at least three monthly by the GP. All medication charts reviewed have ‘as needed’ medications prescribed with an individualised indication for use. The medication charts reviewed identified that the GP had seen and reviewed the resident medication 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. | FA | The service employs a qualified head chef Monday to Friday who is supported by a weekend cook and kitchen staff. All staff have been trained in food safety and chemical safety. A four weekly seasonal menu had been designed in consultation with company chefs and the dietitian at organisational level. The service has been awarded a continuous improvement rating for increased satisfaction with the meals and dining experience. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as vegetarian and pureed/soft and gluten free meals are provided. Food is delivered in scan boxes and served from bain maries in the dementia unit and serviced apartments. Fridge and freezer temperatures are checked daily. Chilled goods temperatures are checked on delivery. Twice daily food temperatures are monitored daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service is received from resident meetings, surveys and audits. The head chef maintains regular contact with residents. |
| 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 right to appeal against assessment outcome policy states the manager, at every stage, will inform the resident/family of other options. The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry was referred back to the needs assessment service 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 facility has embedded the InterRAI assessments within its clinical practice. InterRAI initial assessments and assessment summaries were evident in the files reviewed. Risk assessments have been completed on admission and reviewed six monthly, as part of the evaluation process. Additional assessments such as management of behaviour and wound care were completed according to need. In the resident files reviewed, the outcomes of all assessments, needs and supports required, were reflected in the care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed were comprehensive and demonstrated service integration and input from allied health.  All resident care plans sampled were resident centred and support needs and interventions were documented in detail.  Family members interviewed confirm care delivery and support by staff is consistent with their expectations.  Care plans were amended to reflect changes in health status and were reviewed on a regular basis. |
| 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. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit.  Wound assessments, treatment and evaluations were in place for all current wounds. Wounds in the dementia care unit were six skin tears and two minor lesions. In the rest home there were four minor wounds, one leg ulcer and one pressure injury. In the hospital, there were three skin tears and four pressure injuries (link 1.3.3). Adequate dressing supplies were sighted in the treatment rooms.  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 RN's interviewed.  Monitoring forms in place include (but not limited to) monthly weight, blood pressure and pulse, food and fluid charts, restraint monitoring, pain monitoring, 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 | The activity team (two activities coordinators and one diversional therapist for the dementia unit) implement a separate activity programme for the rest home/hospital, serviced apartments and dementia unit. All activity team members have a current first aid certificate. The Ryman Engage programme is currently delivered Monday to Friday in all areas. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group and are gender appropriate.  Activities were observed to be delivered simultaneously in the rest home/hospital and dementia unit. Rest home residents in the serviced apartment may choose which programme to attend. 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. There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events. On-site church services are held in the facility chapel.  A record is kept of individual residents activities. Activity staff complete recreational progress notes in the residents' files. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan.  Resident meetings were held bi-monthly in the rest home/hospital and serviced apartments. Six monthly relative meetings are held in the dementia unit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by registered nurses’ six monthly or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, activities staff and resident/family. Family are notified of the outcome of the review if unable to attend. There is at least a three monthly review by the medical practitioner. Family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| 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 | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident’s condition had changed and the resident was reassessed for a higher level of care. Discussion with the clinical lead and two RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services. |
| 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 were 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 prevention and 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 and a spills kit were available. |
| 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 17 March 2016.  The facility employs a head maintenance person and grounds staff full time. Daily maintenance requests are addressed and a 12 monthly planned maintenance schedule is in place and signed off monthly. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment.  Hot water temperatures in resident areas are monitored and temperature recordings reviewed were between 43-45 degrees Celsius. Contractors are available 24 hours for essential services.  The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids.  Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided. There is a designated smoking area in the rest home area of the care centre.  The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.  The dementia care unit provided an open plan dining/lounge area with free and safe access to an outdoor courtyard with gardens, seating and shade. |
| 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 bedrooms are single occupancy and have ensuites. There were communal toilets located closely to the communal areas. 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 were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. 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 | The care centre has a separate dining room for the rest home and hospital residents. There is a large lounge with seating placed to allow for individual or group activities. There is a smaller lounge/library area and seating alcoves throughout the facility. The communal areas are easily accessible. The dementia care unit has a spacious open plan dining/lounge area with seating placed appropriately to allow for low stimulus, small group and individual activities. The communal areas were easily and safely accessible for residents. |
| 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 of the cleaning and laundry service. Laundry and cleaning audits were completed as per the RAP programme. The laundry had an entry and exit door with defined clean/dirty areas.  There is a secure area for the storage of cleaning and laundry chemicals for the laundry.  There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The service has been awarded a continuous improvement rating for the labelling process that has reduced the number of missing clothing items. |
| 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. Emergency management, first aid and cardiopulmonary resuscitation (CPR) are included in the mandatory in-service programme. There was a first aid trained staff member on every shift. The Village has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has one emergency generator onsite, which is serviced by an external contractor. There are gas BBQs available in the event of a power failure. Emergency lighting is in place, which will last for four hours. There are civil defence kits in the facility and stored drinkable and non-drinkable water on site. Electronic call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. |
| 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 prevention and control programme is appropriate for the size and complexity of the service. There is an infection prevention and control responsibility policy that included a chain of responsibility and an infection prevention and control officer’s job description. The infection prevention and control programme is linked into the quality management system via the RAP. The infection prevention and control committee is combined with the health and safety committee which meets bimonthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from head office and 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. An appointed registered nurse is responsible for infection prevention and control at the facility. She has been in the role for three weeks and has a signed job description for the role. |
| 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. They include (but not limited to) the village manager, the assistant manager, the clinical manager, the infection prevention and control officer/the quality coordinator, the health and safety representative, the educator, a caregiver representative and maintenance staff. 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 were comprehensive infection prevention and control policies that were current and reflected 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 infection prevention and control officer has completed online e-learning infection prevention and control training since commencing in the role. 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 in turn is responsible to the village manager. An individual infection report form is completed for each infection. Data is logged into an 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 Jane Winstone include discussion on infection prevention control. The IPC 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 no outbreaks at the facility since last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. The organisation is working towards becoming restraint-free.  There was one resident using an enabler (bedrail) and two residents with restraints during the audit. The resident file was reviewed where an enabler (bedrails) was in use. Voluntary consent and an assessment process had been completed. The enabler is linked to the resident’s care plan and is regularly reviewed.  Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours. |
| 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 restraint approval process is described in the restraint minimisation policy. The restraint coordinator is a registered nurse with a job description that defines the role and responsibility of the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The approval group meets six monthly. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, approval group, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. Two hospital level residents’ files with restraint use (bedrails) were reviewed. Completed assessments considered those listed in in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator/approval group. The use of restraint and risks identified with the use of restraint was linked to the two resident care plans reviewed. Internal audits conducted, measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two residents’ files where restraint was in use.  A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the ongoing reassessment for the residents on the restraint register, and six-monthly as part of the care plan review. Families are included in the review of restraint use. Files reviewed for residents with restraint use evidenced evaluation were up to date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraints are discussed and reviewed at the six-monthly restraint meetings, attended by the restraint coordinator and members of the approval group (village manager, clinical manager, GP, unit coordinators, DT and a caregiver). Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, any updates to the restraint programme, and staff education and training and review. |

# 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 | Jane Winstone follows the organisational in-service education programme. It was noted in July 2015 that staff attendance at the in-service education was low. Staff were asked for their feedback on why the education programme was not well attended. A number of changes were made as to how education and training was delivered. This included offering education separately from the general staff meetings, night staff education being provided at handover, and the content of the in-services being provided in written format to each area. Staff who did not attend in-services were followed up by the in-service educator. | The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of finding. There is evidence of action taken based on findings, that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example: Ranges of initiatives were introduced to increase staff attendance at in-services. The initiatives introduced resulted in an improvement at staff attendance at in-services. From 1 December 2014 to 30 May 30 2015 only 20% of staff achieved 60% or higher attendance at in-service. For the period 1 June 2015 to 31 October 2015, 55% of staff achieved 60% attendance at staff meetings. Feedback from residents identified that Jane Winstone has performed well in recent residents & relatives’ satisfaction surveys, ranking in the top six villages in the Rymans group. Their particular strengths in the survey were (but not limited to) care provision and communication. |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | The 2014 resident survey identified a need to improve the quality and variety of meals provided to meet the residents dietary preferences. The service also identified a need to improve the dining experience for the residents. | Feedback and suggestions were sought from the residents through meetings, review of resident dietary forms and verbal and written concerns. The hospitality manger and head chef were involved in the review of resident dietary forms for dislikes, likes, dietary needs and the menu reviewed to meet the majority of residents preferences. The dietitian was involved in the review of the four-week summer menu. The evening meal offers two options. The two meals are plated and shown to the residents prior to ordering their meals. The menus include a day for chef’s choice, themed meals and resident’s choice. Each resident receives a copy of the menu, which is also displayed. Improving the dining experience for residents included a change in décor and furniture to enhance the surroundings, staff training on presentation of meals and special diets and ongoing communication with staff and residents.  Residents and relative interviewed on the day of audit commented positively on the meals provided and the overall dining experience. The February 2015 resident survey on the meals and meal service increased to 72% satisfaction from 31% meal satisfaction in the May 2014 survey. |
| Criterion 1.4.6.2  The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness. | CI | A continuous improvement project was commenced in February 2014 to increase resident and relative satisfaction with laundry services. Missing/lost clothing items had been identified as a resident/relative concern in resident surveys and resident meetings. | Each resident was provided with individually labelled laundry bags for their personal clothing. The organisation purchased a labelling machine and recruited for a new laundry shift whose responsibility was to label all resident personal items on admission and as required. All staff received training on the new labelling machine and laundry processes. Residents and relatives were informed of the labelling procedure. Ongoing discussions at the resident meetings and laundry audits evidenced an improvement in laundry procedures.  Surveys results for March 2015, resident meeting minutes, and resident/relative interviews on the day of audit evidenced there has been a marked reduction in the number of personal clothing and they were very satisfied with the laundry service. The implementation of a laundry labeller system and individualised clothing bags per resident has reduced the amount of missing/lost items of personal clothing. Photos taken before the project and at the conclusion of the project, evidence successful implementation of the use of the labelling machine. A visit to the laundry on the day of audit demonstrated evidence of the system being implemented with a small amount of clothing un-named. |

End of the report.