

# Jane Mander Retirement Village Limited - Jane Mander Retirement Village

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Jane Mander Retirement Village Limited
<b>Premises audited:</b>	Jane Mander Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 5 May 2016      End date: 6 May 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	116



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Jane Mander is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia level care for up to 142 residents. On the days of the audit there were 116 residents including nine residents receiving rest home level of care in serviced apartments. A village manager, who is supported by clinical 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.

An improvement is required around care plan interventions.

The service is commended for achieving continuous improvement ratings around good practice, the volunteer programme 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.
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Jane Mander provides care in a way that focuses on the individual resident's quality of life. There is a Māori Health Plan and implemented policy supporting practice. Cultural assessments are undertaken on admission and during the review process. Policies are being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents and families. Care plans reviewed accommodated the choices of residents and/or their family. Complaint processes are being implemented and complaints and concerns are managed appropriately. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Jane Mander is implementing the Team Ryman programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Jane Mander provides clinical indicator data for the three services being provided (hospital, rest home and dementia care). There are human resources policies including recruitment, selection, orientation and staff training and development. The service had an

induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete InterRAI assessments, risk assessments, care plans and evaluations within the required timeframes. 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 an admission, visits and reviews the residents at least three monthly.

The activity team provide 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. A village friend's volunteer group are involved in the programme. 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.

A dietitian, at an organisational level, designs the menu. 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

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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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

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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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 coordinator oversees restraint/enabler usage within the facility. The service currently has ten residents using restraints and four residents voluntarily

using enablers. The restraint coordinator maintains a register. The restraint approval committee reviewed restraint use. Staff regularly receive education and training in restraint minimisation and managing behaviours that challenge.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection 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. 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 one outbreak that was well managed, 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)
<b>Standards</b>	3	46	0	1	0	0	0
<b>Criteria</b>	3	97	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Six families (one rest home, one hospital and four dementia care) and eight residents (five rest home, one hospital and two rest home in serviced apartments) interviewed, stated they were provided with information on admission which included the Code. Interview with 10 care assistants (three rest home, three hospital, three dementia care and one serviced apartments) demonstrated an understanding of the Code. Residents and relatives confirm staff respect privacy and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>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. Copies of EPOA are kept on the residents file. Ten caregivers, five registered nurses (RN) and two enrolled nurses (EN) interviewed confirmed verbal consent is obtained when delivering care. Discussion with family member's (one rest home, one hospital and four dementia care relatives) stated that the service actively involves them in decisions that affect their relative's lives.</p>

		Eleven resident files sampled (three dementia, three rest home, one rest home resident in the serviced apartments and five hospital residents in the care centre) have signed admission agreements.
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. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy is being implemented at Jane Mander. The village manager has overall responsibility for ensuring all complaints (verbal or written), are fully documented and investigated. The facility has an up-to-date complaints register. Concerns and complaints are discussed at relevant meetings. There were six documented complaints made in 2015. Follow-up letters, investigation and outcome was documented. Discussion with residents and relatives confirmed they were provided with information on the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code. There was also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives confirmed information had been provided around the Code. Large print posters of the Code and advocacy information were displayed through the facility. The village manager reported having an open door policy and described discussing the information pack with residents/relatives on admission. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support resident privacy and confidentiality. A tour of the Jane Mander facility confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. There were instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Interview with care assistants described how choice is incorporated into resident cares. Staff have attended training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>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 local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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 inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager (RN), unit coordinators (serviced apartment, rest home, hospital and dementia care) and registered nurses (RN) and care assistants confirmed an awareness of professional boundaries. Care assistants interviewed could discuss professional boundaries in respect of gifts.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>Ryman Healthcare has a Team Ryman programme that includes annual planning and a suite of policies/procedures. Policies are reviewed at an organisational level. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. Services are provided at Jane Mander that adhere to the health &amp; disability services standards. An implemented quality improvement programme includes performance monitoring.</p> <p>There are human resources policies/procedures to guide practice and an annual in-service education programme that is incorporated into the Team Ryman programme. There is evidence at Jane Mander that the in-service programme is being implemented. There is a journal club for RNs and enrolled nurses (EN) held bi-monthly in conjunction with the RN/EN clinical meetings. There are implemented competencies for caregivers and qualified nurses. Core competency assessments and induction programmes are being implemented at Jane Mander. RNs have access to external training. Residents and relatives interviewed were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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 on the VCare system met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. Resident and relative meetings are held regularly. There was an interpreter policy and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Jane Mander Retirement Village is a Ryman Healthcare facility, situated in Whangarei. The service currently provides care for up to 112 residents in the care centre at hospital, rest home and dementia level care. There are also 30 serviced apartments certified to provide rest home level of care. There were 116 residents on the day of audit including 28 rest home (including nine rest home residents in serviced apartments), 60 hospital level residents (including 20 in dual purpose beds located in the rest home) and 28 residents in the dementia unit (including two on respite). There were no residents under the medical component. The district health board (DHB) funds one respite bed in the dementia unit. All other residents were under the ARCC agreement.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Quality objectives for the 2015 year have been reviewed and 2016 objectives in place. There is a health and safety, and risk management programme being implemented at Jane Mander.</p> <p>The village manager is a registered nurse who has been in this role for two and a half years. Prior to</p>

		<p>this appointment, she was the clinical manager for the facility for 18 months. A full-time clinical manager supports the village manager. The clinical manager has been in the role for two years and has over 15 years' experience as an RN. RN unit coordinators in each area and clinical advisors at head office support her. Management are supported by a regional operations manager and clinical practice and audit manager (at head office).</p> <p>The village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Ryman policy outlines manager availability, including on call requirements. During a temporary absence, the assistant manager and clinical manager will cover the village manager's role. The assistant manager covers administrative functions and clinical manager covers clinical care. The regional operations manager provides oversight and support. The audit confirmed the service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Jane Mander service continues to implement the Team Ryman Programme, which links key components of the quality management system to village operations. There are full facility Team Ryman meetings monthly. Outcomes from the Team Ryman committee are then reported across the various meetings including the full facility, RN and care assistant meetings. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Health and safety and infection control meetings are held three monthly. Clinical meeting minutes were sighted. Interviews with staff confirmed an understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room.</p> <p>Relative survey was last completed March 2015. Results have been collated with annual comparisons for each service. Areas of concern have been identified and quality improvement plans raised (QIPs) and these have been completed and signed off. Results have been fed back to participants through resident and relative meetings. Team Ryman prescribes the annual internal audit schedule that has been implemented at Jane Mander. Internal audit summaries and QIPs are</p>

		<p>completed where a noncompliance is identified (&lt;90%). Issues and outcomes are reported to the appropriate committee (eg, health and safety). QIPs reviewed are seen to have been closed-out once resolved.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets (eg, falls). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The combined health and safety and infection control committee meet bi-monthly and incidents/accidents and infections are discussed and documented. There is a current hazard register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Jane Mander collects monthly incident and accident data and completes electronic recording of events on the VCare system. Monthly analysis of incidents by type is undertaken by the service and is reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and used for comparative purposes. QIPs have been created when the number of incidents exceeded the benchmark. Fourteen accident incident forms reviewed (five rest home and nine hospital) identified timely RN assessment and post falls assessments where required. QIPs were seen to have been actioned and closed out. Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications. Notifications to relevant personnel were sighted for an outbreak December 2015.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Eight of 18 RNs (including the clinical manager) have completed their InterRAI training.</p> <p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are job descriptions for designated officers. Appropriate recruitment documentation was seen in the 15 staff files reviewed. Performance appraisals are current in all files reviewed. Interview with care assistants inform that management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of current practising certificates is maintained.</p> <p>There is an annual training plan aligned with the Team Ryman programme that was being implemented. Staff 'catch up' folders contain education content for staff to read and sign if they were unable to attend training. There is an aged care education coordinator/EN to support staff working towards the national standards. Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings and completing InterRAI training through</p>

		the Ryman programme. Seventeen out of seventeen care assistants who are employed in the dementia care unit have completed their dementia specific units. Completion of the induction programme and required dementia standards are to be monitored and reported monthly to head office as part of the Team Ryman programme.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	Ryman organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. A fulltime clinical manager oversees the care centre. Each unit in the care centre has a RN unit coordinator. There is at least one RN and first aid trained member of staff on every shift. Interviews with care assistants informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. Agency staff can be used to cover unexpected absences. The village manager and clinical manager, both RNs, work full time Monday to Friday and are on call 24/7.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	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 and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard in both areas. Care plans and notes were legible and where necessary signed (and dated) by a RN. Entries reviewed were legible, dated and signed by the relevant care assistant or RN including designation. Individual resident files demonstrate service integration.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>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.</p> <p>The admission agreement reviewed aligns with the service's contracts.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>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, enrolled nurses and senior care staff in the dementia care unit who administer medications, have been assessed for competency on an annual basis. Qualified nurses and care staff interviewed were able to describe their role about medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly.</p> <p>Standing orders are not used. Two self-medicating residents in the rest home had been assessed and reviewed three monthly by the GP and RN as competent to self-administer.</p> <p>Twenty-two (10 hospital, six rest home and six dementia care) medication charts were reviewed. 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 indication for use. The medication signing sheets corresponded with the medication charts.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a qualified head chef who is supported by cooks and kitchen assistants. 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. All meals are prepared and cooked on-site.</p> <p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes such as a 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 pureed/soft and diabetic desserts are provided. Food is delivered in scan boxes and served from bain-maries in each of the unit kitchenettes. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored 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</p>

		head chef maintains regular contact with residents.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The facility has embedded the InterRAI assessments within its clinical practice. Risk assessments have been completed on admission and reviewed six monthly as part of the evaluation process. The outcomes of InterRAI assessments and risk assessments (triggered) were reflected in the care plan. Additional assessments such as behavioural, wound and restraints 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.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans were resident centred and support needs and interventions were documented in detail to reflect the outcomes of clinical assessments. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans reviewed were amended to reflect changes in health status and were reviewed on a regular basis. Residents and family stated they were involved in the care planning and review process.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>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 or nurse specialist consultant.</p> <p>Wound assessments, treatment and evaluations were in place for all current minor wounds, two chronic ulcers and one stage 1 pressure injury (hospital level). Adequate dressing supplies were sighted in the treatment rooms. Wound care advice and support can be sought from the DHB district nursing service and wound product representative.</p> <p>Continence products are available and resident files include a three-day urinary continence</p>

		assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and RNs interviewed could describe this.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>Four activity coordinators implement a separate activity programme for the rest home, hospital and dementia unit. All activity team members have a current first aid certificate. One activity coordinator in the dementia care unit has completed dementia unit standards and the other is progressing through the standards.</p> <p>The Ryman 'Engage' programme is currently delivered Monday to Friday in the rest home and hospital areas. There are two activity coordinators (one for each unit) providing activities in the dementia unit over the seven day week from 9.30am – 6.30pm.</p> <p>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. Residents in the dementia care unit were observed being taken for supervised walks outside. Spontaneous pet therapy sessions occur. Activities were observed to be delivered simultaneously in the rest home, hospital and dementia unit. Rest home residents in the serviced apartment may choose to attend either the serviced apartment or rest home programme. 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. 'Village friends' is a group of village volunteers who are involved in the activities programme. The volunteer group has been beneficial for residents who require one-on-one time and small group activities such as the men's group.</p> <p>There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events. Wheelchair access vans are hired for special community outings. On-site church services are held on Sundays in the on-site chapel.</p> <p>Activity assessments are completed for residents on admission. 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. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</p>	FA	<p>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. The multidisciplinary review involves the RN, GP, activities staff and resident/family.</p>

<p>and timely manner.</p>		<p>The 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. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. 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 manager and three RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There 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 product use information was readily available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 22 December 2016.</p> <p>The facility employs a maintenance person (full-time and on-call) and gardens and grounds staff. The maintenance person has a current advanced site safety certificate. Daily maintenance requests are addressed and a 12-monthly planned maintenance schedule is in place and has been signed off monthly (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. Three new gas boilers have been installed in the serviced apartment area due to low water temperatures. Contractors are available 24 hours for essential services.</p> <p>Environmental improvements include the replacement of lights to LED lights providing better lighting throughout the facility and less maintenance. The facility has wide corridors with sufficient space for</p>

		<p>residents to mobilise safely using mobility aids.</p> <p>Residents were observed safely accessing the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>The care assistants and RNs interviewed stated they have sufficient equipment to safely deliver cares as outlined in the resident care plans.</p> <p>The dementia care unit includes an open plan dining/lounge area. There is free and safe access to an outdoor deck area with raised gardens, seating and shade. There is a men's shed in one of the courtyards.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms are single occupancy, and have toilet and shower ensembles. There were communal toilets located close to the communal areas. Toilets have privacy locks. The rest home has a spa bath available. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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. All beds are electric with some ultra-low beds in place. The bedrooms in the dementia care unit have sensor lighting in the bathrooms that are activated by the bed sensor pad on movement.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each unit has a functioning kitchen unit and dining area. Large lounges have seating placed to allow for individual or group activities. There is a smaller lounge/library area and seating alcoves in the rest home and hospital units. 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. There is a smaller family/whānau lounge for quiet activities or family visits. The communal areas in the dementia unit are easily and safely accessible for residents.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	CI	<p>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 Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents 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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are 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 dated 14 January 2010. Fire drills occur six monthly. The service has an emergency generator onsite, gas barbeque, sufficient water and food in the event of an emergency event. Emergency lighting is in place. An electronic call bell system was evident in all resident's rooms and ensuites, communal toilets and communal lounge and dining areas. The building is secure after hours. The dementia care unit has secure access.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately ventilated and heated, with under floor heating. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. A registered nurse in the dementia care unit is the infection prevention and control officer. She has a signed job description defining the responsibilities of the role. The infection prevention and control programme is linked into the quality management system via the Team Ryman programme. The infection prevention and control committee is combined with the health and safety</p>

<p>to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>committee, which meets bimonthly. The facility meetings also include a discussion of infection prevention and control matters. The programme is reviewed annually from head office and directed via the Team Ryman annual calendar.</p> <p>Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine. Hand sanitisers are strategically placed throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control committee (combined with the health and safety committee) consists of a cross-section of staff from areas of the service. The infection control and prevention officer has completed training via the Ryman annual infection control teleconference and has attended external education September 2015.</p> <p>The facility also has access to an infection prevention and control consultant, nurse specialist from the DHB, public health, GPs and expertise from within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>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 policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>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. Six sessions of infection control education were held over 2015 with 89 staff attending. Resident education occurs as part of providing daily cares.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance programme is organised and promoted via the Ryman calendar. Effective monitoring is the responsibility of the infection prevention and control officer who is a registered nurse. 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 bimonthly combined health and safety, and infection prevention and control (IPC) meetings. Six monthly comparative summaries of the data are completed and forwarded to head office. All meetings held at Jane Mander include discussion on infection prevention control. The IPC programme is incorporated into the internal audit programme. Infection rates are benchmarked across the organisation.</p> <p>There has been one outbreak in the dementia care unit December 2015, which was well managed and contained. The service was commended on the way in which the outbreak was managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>A restraint policy in place 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. On the day of audit there were four residents using enablers (bedrail). There are 10 hospital residents with restraints (bedrails and chair briefs). The resident files were 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 reviewed six monthly.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The clinical manager is the restraint coordinator for the facility and has defined responsibilities included the job description. The restraint approval committee meet six monthly. There is ongoing education including challenging behaviours. Quality and clinical meetings include discussion on restraint. Staff carry out and record restraint monitoring including cares delivered during the restraint period.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous</p>	<p>FA</p>	<p>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</p>

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form was completed for the 10 residents requiring restraint (sighted). 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 coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluations occur three monthly as part of the ongoing reassessment for residents on the restraint register, and as part of their care plan review. Families are included as part of this review where possible.
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 is in place, which includes restraint competencies. Internal restraint audit completed in August 2015 achieved a 96% result.

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	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. Progress notes document changes in health and significant events. Interventions for pain relief and challenging behaviours had not been documented.	1) Four behaviour incidents within one week had not been recorded on the behaviour chart for one hospital resident. Although not recorded on a behavioural chart they were documented in the progress notes. 2) One rest home resident who had received controlled drugs for pain relief did not have the administration and effectiveness of pain relief recorded in the progress notes.	<p>1) Ensure behaviours are recorded on the behaviour chart. 2) Record in the progress notes when 'as required' pain relief is given and the effectiveness of the pain relief.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Ryman provides a comprehensive induction programme that ensures healthcare assistants achieve foundations Level 2. The progress of staff completing induction programmes is monitored and reported monthly to head office, as part of the Team Ryman programme. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings. There is evidence of action taken based on findings that has made improvements to service provision. The projects include</p>	<p>Using staff feedback, Jane Mander created an improved and structured orientation process for new staff to ensure that they feel welcomed, supported, confident and competent in their role(s), including the introduction of a Dedicated Education Unit (DEU) for nursing staff in partnership with Northtec. Jane Mander initiated and commenced the new induction process 1 November 2014. An action plan was developed for the orientation process. Orientation leaders/buddies were set up within all departments to ensure there is continual support and guidance for all new staff. Education was provided for the orientation leaders/buddies on the expectations of the role.</p> <p>Induction statistics were reviewed 31 December 2014. As at 1 December 2014, the percentage of all employee inductions at Jane Mander were completed as 100%, the percentage of overall inductions completed was 93%. In the year 2015, the percentage of all employee inductions at Jane Mander completed within the specified timeframe was 100%, the percentage of overall inductions completed was 96%.</p> <p>Outcomes of the new orientation process; Staff feel more confident and competent within their roles, staff feel supported by the entire team, improved</p>

		reviewing if the improvements have had positive impacts on resident safety or resident satisfaction.	<p>team culture, induction completion rate improved. Service provided to the residents is improved, resident satisfaction with care improved and there have been improved call bell responses.</p> <p>On reviewing the Jane Mander induction process and statistics, Ryman rolled out nationally, the Ryman Induction Day Plan on 1 October 2015. The implementation of the DEU has had a positive impact on the improved resident and relative satisfaction with care provided and communication. Comprehensive buddy checklist forms were developed and introduced along with induction day timetables. All new staff taken through the induction process do not begin their job until the orientation plan has been completed and signed off. Induction status is reviewed during monthly team meetings and is discussed at the monthly staff full-facility meeting.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service identified there were some residents in the hospital unit that were at risk of isolation and a 'village friends' programme was introduced into the hospital unit in July 2014. The Engage programme was implemented, that offered more variety and activities tailored to meet the needs of groups and individuals.</p>	<p>Twelve townhouse/serviced apartment residents (including five men) developed a roster to visit hospital residents twice weekly. One resident is the village friend's coordinator and meets regularly with the activities coordinator to discuss activities and residents who will benefit from one-on-one time. Village friends are involved in activities such as hand massages, singing, flower arranging, reading, entertaining, discussions and chats with residents. Men enjoy having other men around to chat and do 'bloke stuff' with. Male volunteers are actively involved with the men's group. The village friends have a roster of volunteers available to provide companionship and reassurance for residents who are in palliative care and provide support for the families. The village friends have a rapport with the residents and their families that strengthen the feeling of family and community. The initiative has been so successful the village friends now visit residents in the rest home since November 2014, and weekly in the dementia unit since March 2015. There has been an increase in resident satisfaction around activities as evidenced in the February 2015 survey results. The service identified the increased satisfaction is due to the improved Engage activities programme which includes the village friends and men's group initiative. All residents and relatives interviewed on the day of audit confirmed their satisfaction with the activities and the one-on-one companionship provided to the residents.</p>
<p>Criterion 1.4.6.2</p>	CI	<p>A continuous improvement project was commenced in January 2015</p>	<p>Each resident was provided with individually labelled laundry bags for their personal clothing. The purple resident clothing bags were seen in resident</p>

<p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>		<p>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.</p>	<p>ensuites. The organisation purchased a labelling machine and recruited for a new laundry shift whose responsibility is to label all resident personal items on admission and as required. All staff received training on the new labelling machine and laundry processes. The laundry person interviewed on the day of audit could describe the procedure for reducing the amount of missing clothing. Residents and relatives were informed of the labelling procedure. Ongoing discussions at the resident meetings and laundry audits evidenced an improvement in laundry procedures.</p> <p>Resident satisfaction survey results for February 2015 evidenced increased satisfaction with the laundry service.</p> <p>Resident/relative interviews on the day of audit confirmed there has been a marked reduction in the number of personal clothing lost or missing 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 were taken before the project and at the conclusion of the project, evidenced 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.</p>
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End of the report.