# Ryman Healthcare Limited - Margaret Stoddart 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:** Ryman Healthcare Limited

**Premises audited:** Margaret Stoddart Retirement Village

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 16 May 2016 End date: 17 May 2016

**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:** 49

# 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

Margaret Stoddart is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home care level care for up to 41 residents in the care centre and rest home level of care for up to 25 residents in serviced apartments. On the day of audit there were 49 residents including 8 residents receiving rest home level of care in serviced apartments. The service is managed by an experienced village manager who is a registered nurse with a current practising certificate. She is supported by an experienced clinical manager. 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 recognition of Māori, good practice, quality improvements including reduction of falls and pressure injuries, the engage men’s group, meal satisfaction, laundry service and infection surveillance.

## 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. |

Margaret Stoddart provides care in a way that focuses on the individual residents' quality of life. There is a Māori health plan and implemented policy supporting practice. Cultural assessment has been 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) was readily available to residents and families. Care plans accommodated the choices of residents and/or their family. Complaint processes were being implemented and complaints and concerns were 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. |

 Margaret Stoddart implements the ‘Team Ryman Programme’. The programme 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. Annual resident/relative satisfaction surveys have been completed and there has been regular resident/relative meetings.  Quality and risk performance has been reported across the various facility meetings and to the organisation's management team.  There are human resources policies including recruitment, selection, orientation and staff training and development.  There is an induction programme in place that provides new staff with relevant information for safe work practice.  There is an in-service training programme covering relevant aspects of care and support and external training has been supported.  The organisational staffing policy aligns with contractual requirements and included skill mixes.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is a comprehensive information package for residents/relatives on admission to the service. InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses 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 reviewed have been updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three monthly.

The activity team provide an activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the group of residents including a men’s group.

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. Residents interviewed responded favourably to the food that is 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 toilet and hand basin ensuites. There are adequate numbers of communal shower rooms. 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. |

There is a restraint policy in place with associated procedures and forms. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with restraint or enablers at Margaret Stoddart. Staff have been trained in restraint minimisation and the management of challenging behaviour.

## Infection prevention and control

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

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team has 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 since the last audit that was well managed.

## 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** | 3 | 42 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 8 | 85 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | 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). One family member (rest home) and seven residents (rest home) interviewed stated they were provided with information on admission which included the Code. Interview with four care assistants (three rest home 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. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately. Copies of EPOA are kept on the residents file. Five healthcare assistants interviewed confirmed verbal consent is obtained when delivering care. Discussion with a family member stated that the service actively involves them in decisions that affect their relative’s lives. Eight resident files sampled (including one rest home resident in serviced apartment and one respite care resident) have signed admission agreements. |
| Standard 1.1.11: Advocacy And SupportService 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 reviewed include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers 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. Relative 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 Margaret Stoddart. 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 DeliveryConsumers 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 informed 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. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Ryman has policies that support resident privacy and confidentiality. A tour of the Margaret Stoddart facility confirmed there are 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. Interviews with care assistants described how choice is incorporated into resident cares. Staff have attended training on abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 the local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives inform values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager, RNs and care assistants confirmed an awareness of professional boundaries. Care assistants interviewed could discuss professional boundaries in respect of gifts. |
| Standard 1.1.8: Good PracticeConsumers 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 policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based around their policies.A range of clinical indicator data is collected and reported through to head office for collating, monitoring and benchmarking between facilities. Feedback is provided to staff via the various meetings as determined by the Ryman programme (previously known as Ryman Accreditation Programme RAP). Quality Improvement Plans (QIP) are developed where results do not meet targets. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch (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. There are a number of examples where this has occurred (link CI 1.2.3.6). A number of quality initiatives have been implemented including (but not limited to): implementation of the Engage Programme to increase attendance at Engage programme and resident enjoyment, implementation of men’s club, improve residents’ satisfaction with meals and enjoyment with the dining experience, improving satisfaction with laundry service & reducing lost property, introduction of One Chart medication programme and introduction of MyRyman rostering programme. |
| Standard 1.1.9: CommunicationService 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. Margaret Stoddart enters incidents into the Ryman VCare system. 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 have been notified following a change of health status of their family member. Resident and relative meetings are held regularly. There is an interpreter policy and contact details of interpreters were available.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Margaret Stoddart Retirement Village is a Ryman Healthcare facility, situated in Christchurch. The service currently provides care for up to 66 residents at rest home level care including 25 serviced apartments that are certified to provide rest home level of care. There were 49 residents in the facility on the day of audit including 8 rest home residents in serviced apartments. There were five residents on respite care.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 are in place. There is a health and safety and risk management programme being implemented at Margaret Stoddart. The village manager is registered nurse (RN) who has been in this role for four years. The village manager is supported by a full-time clinical manager. The clinical manager has been in the role for 12 years and has over 30 years’ experience in aged care. Management are supported by a regional operations manager and clinical practise and auditor manager (at head office). The village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | Ryman policy outlines manager availability including on call requirements. During a temporary absence, the clinical manager will cover the village manager’s role. 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. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Margaret Stoddart 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 assistants. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). 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.Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to be completed to maintain competence. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room. Relative survey was last completed March 2015. Results have been collated with annual comparisons for each service. Areas of concern were identified and quality improvement plans raised (QIPs) and were completed and signed off. Results were fed back to participants through resident and relative meetings. The Team Ryman prescribes the annual internal audit schedule that has been implemented at Margaret Stoddart. Audit summaries and QIPs are completed where a noncompliance is identified (<90%). Issues and outcomes are reported to the appropriate committee e.g. Team Ryman, health and safety. QIP’s reviewed are seen to have been closed out once resolved.Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data and development of QIPs when volumes exceed targets (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 discussion of incidents/accidents and infections is discussed and documented. There is a current hazard register. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Margaret Stoddart 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. Thirteen 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.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are job descriptions for Team Ryman officers. Appropriate recruitment documentation was seen in the eight staff files reviewed. Performance appraisals were 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 practising certificates is maintained. There is an annual training plan aligned with the Team Ryman that was being implemented. Staff ‘catch up’ folders contain education content for staff to read and sign if they were unable to attend training. Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings and completing interRAI training through the Ryman programme. A register of current practising certificates is maintained. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a staffing levels and skills mix policy that documents rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents and rosters are in place. The service provides a clinical manager (RN) Sunday to Thursday and an RN Friday and Saturday. There is a RN on duty seven days a week. Interviews with care assistants confirmed that staffing levels were good and they were well supported by management. Agency staff can be used to cover unexpected absences. They stated the village manager was responsive to increased work levels when there were high dependency residents. The village manager and clinical manager share the 24/7 on call duty. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Information containing personal resident information is kept confidential 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.  |
| 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. The relative interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the service’s contracts.  |
| 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. Medication reconciliation is completed by clinical manager/RN on delivery of medication and any errors are fed back to pharmacy. Senior care staff who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly. Standing orders are not used. Two self-medicating residents (one respite care) had been assessed and reviewed by the GP and RN as competent to self-administer. Sixteen medication charts were reviewed on the electronic medication system. 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.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All food and baking is prepared and cooked on-site. The qualified cooks are supported by kitchen assistants. All staff have been trained in food safety and chemical safety. There is a four weekly seasonal menu that had been designed in consultation with company chefs and the dietitian at organisational level. The cook 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 pureed/soft, diabetic desserts and gluten free are provided. 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 daily and recorded. All foods were date labelled. A cleaning schedule is maintained. The cook maintains regular contact with residents and the village manager is involved in the serving of meals. Feedback on the service is received from daily resident contact, resident meetings, surveys and audits.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is 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. 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 plans reviewed. Additional assessments such as behavioural, wound and restraints 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 were resident centred and support needs and interventions were documented in detail to reflect the outcomes of clinical assessments.  Family member 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. Residents and family stated they were involved in the care planning and review process. Residents (as appropriate) and relatives interviewed stated that they were involved in care planning and reviews. |
| 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. The relative 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. Care plans reviewed had been updated to reflect the changes in resident needs/supports. Wound assessments, treatment and evaluations were in place for three minor wounds, one chronic wound and two surgical wounds. Adequate dressing supplies were sighted in the treatment rooms. Wound care advice and support can be sought from the district nursing service and wound product representative. 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. Progress notes document changes in health and significant events.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | There is a qualified diversional therapist for the rest home and an activity coordinator for the serviced apartments/townhouses. The DT is employed for 35 hours a week Monday to Friday. She is supported by a lifestyle manager at head office and attends on-site education and recreational workshops and has a current first aid certificate. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group. Rest home residents in the serviced apartment may choose to attend either the serviced apartment or rest home programme. Daily contact is made with residents who choose not to be involved in the activity programme. There are regular outings/drives offered for all residents, weekly entertainment and involvement in community events. Residents are encouraged to maintain links with the community including fundraising for charities and local theatre such as the current Wizard of Oz productions. The men’s club numbers of attendance have continued to increase since the club was launched.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.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Six of eight care plans had been evaluated by registered nurses’ six monthly. One resident had not been at the service six months and the other resident was in for respite care. 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. 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 member 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 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. |
| 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 product use information was readily 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 1 July 2016. The facility employs a maintenance person (full-time and on call) and gardens and grounds staff. The maintenance person ensures daily maintenance requests are addressed. He maintains a 12 monthly planned maintenance schedule which has been signed off monthly as completed (sighted). Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor.Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius. Environmental improvements include the replacement of existing wardrobes to more spacious standing wardrobes in each bedroom. All wardrobes have been securely bracketed. All bedrooms now have wall mounted televisions. Rooms are refurbished as they become vacant. 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 safely. Seating and shade is provided. The care assistants and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 toilet and basin ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. There are adequate communal showers available with privacy locks and privacy curtains in place. 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 DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The facility has a large communal combined dining room for rest home and serviced apartment residents. The large main lounges have seating placed to allow for individual or group activities. A smaller lounge (guest lounge) is available for quieter activities such as reading and for visitors. A computer is set up in the guest lounge for communal use.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers 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 Ryman 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 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. Fire drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. Gas barbeques and torches are available in the event of a power failure. Emergency lighting is in place, which is regularly tested. There are civil defence kits in the facility. Supplies of stored drinkable and non-drinkable water are held on-site.The call bell system is evident in resident’s rooms, lounge areas and toilets/bathrooms. Residents in the rest home, hospital and serviced apartments were observed during the audit to be in close proximity to their call bells. Calls bells are also readily available in communal areas. Security staff are employed from dusk to dawn, seven days a week.  |
| 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 ventilated and heated with underfloor heating. All rooms have external windows with plenty of natural sunlight.  |
| Standard 3.1: Infection control managementThere 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. The infection prevention and control committee is combined with the health and safety committee, which meets bi-monthly. 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 quality programme. The programme is reviewed annually and a six month analysis is completed at Margaret Stoddart. The facility has developed links with the GPs, local laboratory, the infection control and public health departments at the local DHB. The clinical manager/RN is responsible for infection prevention and control at the facility. A norovirus outbreak June 2015 was well managed and included a debrief meeting to review overall management by staff.Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control committee (combined with the health and safety committee), is made up of a cross section of staff from areas of the service. The IC officer has completed infection control and prevention training within the organisation and online training. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs and expertise from within the organisation.  |
| Standard 3.3: Policies and proceduresDocumented 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 policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The orientation/induction package includes specific training around hand hygiene and standard precautions. 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: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | The surveillance policy described the purpose and methodology for the surveillance of infections. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with restraint or enablers at Margaret Stoddart. Staff are trained in restraint minimisation and the management of challenging behaviour. |

# 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.

|  |
| --- |
| 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 1.1.4.2Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated. | CI | There is an established Māori health plan that includes a description of how they achieve the requirements set out in the contract. There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The policies for Māori identify the importance of whānau. 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 and family/whānau. | Margaret Stoddart implemented an initiative in March 2015 to engage with the local iwi and other community representative groups to improve the involvement of local iwi within the village. The goal of the initiative was to improve the experience and the perception of aged care facilities within the local Māori community. Margaret Stoddart has increased the profile of the village within the local Māori community and have become the preferred place for respite care with regular Māori residents who come in for a “holiday”. There is a poster in the staff room about local iwi within regions to help them understand the iwi groups. The village has a permanent resident who is a Kaumatua. This resident blesses vacant rooms, liaises with the village manager in helping residents settle in and ensures cultural aspects and protocols are followed. The village manager also liaises with the local Māori community group to facilitate visits for residents wishing to attend and also with the local kapa haka group. The outcome of this initiative has led to an increase in permanent Māori residents and respite residents from 1 March 2015 to 30 April 2016. The number of respite residents identifying as Māori during this period has been twelve with four of the residents coming in twice. The number of permanent residents identifying as Māori during this period has increased to three. Of the twelve respite residents identifying as Māori, two have become permanent residents and another resident was admitted directly as a permanent resident. |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Ryman has robust quality and risk management processes which is well established at Margaret Stoddart. The quality programme is directed from Ryman Christchurch (head office). A quality assistant checklist is completed monthly. Six monthly comparative incident and accident reports and infection reports are completed. Policies and procedures cross-reference other policies and appropriate standards. There is an organisational clinical management committee at Ryman Christchurch (head office) that reviews best practice, legislation, standards, research and policy and procedure review. All changes made to policy, procedure and processes are forwarded to Margaret Stoddart for input and review. There is a journal club (registered nurses/enrolled nurses), articles/research and questions directed by Ryman Christchurch are completed at the journal club. There is evidence of clinical development and review of practice at Margaret Stoddart. The focus of care is around a multidisciplinary model and includes input from resident, relatives, care staff, registered nurses and GP. Care planning is holistic and integrated. There is a strong commitment to staff development by way of education and in-service training. There are also experienced registered nurses including the clinical manager, who provide leadership. | The service provides an environment that encourages good practice which 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 findings. 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: the service implemented a project around reducing and better managing incidents of challenging behaviours. An action plan was implemented that included (but not limited to): analysing the incidents, team discussions, liaising with the leisure and lifestyle manager around activities that could be used to engage residents more and further staff education. The evaluation of the project identified reduction in behaviour incidents. The rate has reduced to zero incidents in September to November 2015 and January to February 2016.  |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Robust systems are in place for the collection, analyses and evaluations of quality data. Results are communicated to staff via a variety of forums. A range of data is collected across the service using V-care, an electronic data system. Data is collated and analysed with comprehensive evaluation reports completed monthly and comparative reports six monthly. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other similar service types within Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management meetings, full facility meetings, clinical meetings). Templates for all meetings document action required, timeframe and the status of the actions. | Data collated is used to identify any areas that require improvement. The quality programme for 2016 includes objectives for improving outcomes for residents. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is collected around (but not limited to): falls, skin tears, pressure injuries and infections. Falls in the rest home were identified as an area that required improvement from data collected from 2015. A plan was developed as part of their 2015 quality goals which included identifying residents at risk of falling, providing falls prevention training for staff, reviewing call bell response times, reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the activities programme and reviewing of clinical indicator data. Further initiatives implemented included routine checks of all residents specific to each resident’s needs (intentional rounding), the use of sensor mats, night lights, proactive and early GP involvement and increased staff awareness of residents who are at risk of falling. The plan has been reviewed monthly and discussed at staff meetings. Education and training for staff has been regularly provided. Evaluation identified that the rest home has remained under the limit reference range for falls (11 per 1000 bed nights) in 2015. |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | CI | The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Formal review of the Margaret Stoddart facility objectives takes place annually and informally monthly. Monthly benchmarking occurs throughout the group. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a six month period. Reports and implementation of the quality system is monitored closely by Ryman head office. Internal audits are completed and include the identification of any issues and corrective actions where required. Results are discussed at the monthly quality/management meetings and other facility meetings. Annual resident and relative satisfaction surveys are completed. | Margaret Stoddart has identified quality goals for each year. The service reports on progress to meeting quality goals monthly and annually. One quality goal was around pressure injury prevention. A trend analysis was completed around pressure injury rates. A plan was implemented to meet this quality goal that included (but not limited to): review of pressure relieving equipment for those residents at risk, ongoing in-service education, review of PIs monthly with identified corrective actions, discuss at clinical meetings and management meetings. The 2015 outcome identifies that Margaret Stoddart has remained below upper limit range for rest homes. Ongoing evaluation of the quality goal and strategies are reviewed for effectiveness at monthly meetings. Margaret Stoddart is ranked number one across the Ryman group for lowest rate of stage I pressure injuries. |
| Criterion 1.3.13.1Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | The service identified a need to maintain resident’s enjoyment with the dining experience and satisfaction with the meals. A project was commenced in March 2015 to review the menu in consultation with the hospitality manager, head chef, management and 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 and dietary needs. Trends of dislikes were removed from the menu. A chefs choice was implemented weekly based on what residents prefer. A second tea option was introduced. A comment book is located in the dining room which is reviewed by the village manager daily and signed as acknowledged/addressed, sighted on day of audit. Education was completed for staff around safe food handling, nutritional and oral hygiene. There is continuing feedback and discussion around meals and the dining experience with residents through regular meetings and surveys. Residents and relative interviewed on the day of audit commented positively on the meals provided and the overall dining experience. Satisfaction results for residents (February 2016) evidenced Margaret Stoddart remained the top village within the Ryman group for meal satisfaction and had improved on last year’s results.  |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The Engage programme was commenced in September 2014. The service identified a need for men’s activities and encourage men to be involved in the men’s club. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group. Rest home residents in the serviced apartment may choose to attend either the serviced apartment or rest home programme. Daily contact is made with residents who choose not to be involved in the activity programme.  | The programme includes activities that have been specifically developed to focus on men including weekly rummikin club, morning and afternoon teas, sip and share (beer and playing pool), create club such as modelling buildings, RSA lunches, guest speakers, men’s shed, air rifle shooting, sports afternoons and men’s club breakfast. As at May 2016 there were 26 men in the village (including rest home, serviced apartments and townhouses). In December 2014 attendance numbers had increased to 26 and the average attendance at men’s club for 2016 was 16 – 21 residents.  |
| Criterion 1.4.6.2The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness. | CI | 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. A continuous improvement project was commenced in January 2015 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.  | A continuous improvement project was commenced in January 2015 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 purple resident clothing bags were seen in resident 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. Relative satisfaction survey results for February 2016 evidenced an increase in satisfaction with the laundry service to 87%. The facility results of the relative satisfaction survey was among the top five Ryman villages. Resident/relative interviews on the day of audit confirmed there has been a marked reduction in the number of personal clothing missing and they were very satisfied with the laundry service. Photos taken of amounts of unclaimed clothing (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.  |
| Criterion 3.5.7Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | Infections are included on a register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. Infections are benchmarked across Ryman and quality action plans are identified where infections are above the benchmark. The service has been successful in reducing the number of urinary tract infections and respiratory infections.  | The IC team at Margaret Stoddart identified increasing trends in UTIs May, October and November 2015. A quality initiative was implemented to reduce the number of UTIs. Strategies were documented and implemented including (but not limited to): increasing resident hydration with a variety of fluids, jellies, ice blocks, smoothies; acidophilus yoghurt for residents prone to UTIs; staff education around infection control and UTIs; handover reminders and liaising with the GP to review interventions and medications of those residents with recurrent UTIs. Ongoing review of this action plan from April 2015 to April 2016 included an analysis and review/effectiveness of strategies through the clinical meetings and full facility meetings monthly. The evaluation identified UTIs have reduced (with the exception of one spike November 2015) to below the organisations target range. Margaret Stoddart ranks second within the Ryman group for lowest rate of UTIs for the period April 2015 – April 2016.  |

End of the report.