# Ryman Healthcare Limited - Ngaio Marsh 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:** Ngaio Marsh Retirement Village

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

**Dates of audit:** Start date: 7 June 2016 End date: 8 June 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:** 116

# 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

Ngaio Marsh is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home and hospital level care for up to 114 residents in the care centre and rest home level of care for up to 30 residents in serviced apartments. On the day of audit there were 116 residents including four rest home residents and one respite care resident in the serviced apartments. The service is managed by an experienced non-clinical village manager and experienced clinical manager who is a registered nurse. 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 and staff.

An area for improvement was identified around timely interRAI assessments.

Areas of continuous improvements were identified around reduction of falls, good practice, meal satisfaction and 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. |

Ngaio Marsh 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 have 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. |

Ngaio Marsh implements the teamRyman Programme that provides the framework for quality and risk management and the provision of clinical care.  Key components of the quality management system linked to a number of meetings including staff meetings.  An annual resident/relative satisfaction survey was completed and there were regular resident/relative meetings.  Quality and risk performance was reported across the various facility meetings and to the organisation's management team. 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. |  | Some standards applicable to this service partially attained and of low risk. |

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

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 contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The hospital unit coordinator/restraint coordinator oversees restraint/enabler usage within the facility. The service currently has six residents using restraints and three residents voluntarily using enablers. A register is maintained by the restraint coordinator. Review of restraint use was reviewed by the restraint approval committee. 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. |

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 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** | 2 | 47 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 4 | 96 | 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)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). Four families (two rest home level and two hospital level) and seven residents (all rest home level) interviewed stated they were provided with information on admission which included the Code. Interview with five care assistants (two rest home, two hospital 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 Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in eleven resident files (six hospital, four rest home and one respite care in the serviced apartments) were signed by the resident or their enduring power of attorney (EPOA).  Advanced directives are signed for separately. The clinical manager is currently completing advance care planning for all residents and this is included in the admission process. Completed advance care plans for residents in town houses are available for staff attending emergencies and also entered into the GP practice data base and DHB data base. A goal for 2016 is to complete advance care plans for all residents linking the plans to the GP, DHB and pending ambulance data base.  Copies of EPOA are kept on the residents file where required. Caregivers and registered nurses (RN) 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.  Ten resident files reviewed have signed admission agreements for long term care and the respite care resident has signed a short term agreement. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files 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. Interviews 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 Ngaio Marsh. The village manager has overall responsible 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 eight documented complaints made in 2015 and one in 2016, year to date. 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 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 Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Ryman has policies that support resident privacy and confidentiality. A tour of the Ngaio Marsh 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. Interviews with care assistants described how choice is incorporated into resident cares. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with the local iwi and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. On the day of the audit there were no residents that identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six monthly 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: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the village manager, clinical manager (RN), unit coordinators and registered nurses (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 Practice  Consumers receive services of an appropriate standard. | CI | Ryman Healthcare has a ‘teamRyman Programme’ that includes an annual planning and a suite of policies/procedures to provide rest home and hospital/medical level care. 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 Ngaio Marsh that adhere to the Health & Disability Services Standards. There are human resources policies/procedures to guide practice and an annual in-service education programme that is incorporated into the teamRyman programme. There is evidence at Ngaio Marsh 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 Ngaio Marsh. RNs have access to external training including palliative care education. The service has been awarded a continuous improvement rating for end of life care. Residents and relatives interviewed were positive about the care they receive. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy to guide staff in their responsibility around open disclosure. Ngaio Marsh enters incidents into the Ryman VCare system. Staff are required to record family notification when entering an incident into the system. Incident forms 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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ngaio Marsh Retirement Village is a Ryman Healthcare facility, situated in Christchurch. The service provides hospital (and medical) and rest home level of care for up to 144 residents, including rest home level of care in 30 certified serviced apartments.  The service is divided across two floors. The ground floor has 62 beds (all dual purpose) with 35 RH and 25 hospital. The 1st floor has 52 hospital beds with 51 hospital residents. There were five rest home residents in the serviced apartments including one respite. There were two residents (hospital level) under the medical component of the certification. All other residents were under the ARCC.  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 Ngaio Marsh.  The village manager at Ngaio Marsh is non-clinical and has been in the role since March 2014. The village manager is supported by an experienced full-time clinical manager whom has been in the role for three years. She is supported by RN unit coordinators in each area and clinical advisors at head office. Management are supported by a regional operations manager and clinical practice coordinator (at head office).  The village manager has 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 assistant village manager and clinical manager will cover the village manager’s role. The assistant village 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. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Ngaio Marsh service continues to implement the ‘teamRyman Programme’, which links key components of the quality management system to village operations. There are full facility teamRyman meetings monthly. Outcomes from the teamRyman 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. Interview with staff confirmed an understanding of the quality programme.  Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to be completed to maintain competence. 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 teamRyman prescribes the annual internal audit schedule that has been implemented at Ngaio Marsh. Audit summaries and QIPs are completed where a noncompliance is identified (<90%). Issues and outcomes are reported to the appropriate committee e.g. teamRyman, 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 (e.g., 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 service has been successful in the reduction of falls in the rest home and hospital. 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 | Ngaio Marsh 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 incidents (five rest home and nine hospital) reviewed 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. Appropriate recruitment documentation was seen in the 13 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 practising certificates is maintained.  There is an annual training plan aligned with the teamRyman 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 the teamRyman programme. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a full-time clinical manager. 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, work full-time Monday to Friday and are on call at the weekends. The hospital and rest home unit coordinators are on call during the week.  There is a full-time serviced apartment unit coordinator and care assistants across the AM and PM shift. The rest home staff oversees at night. |
| 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 are 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 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 admission agreement reviewed aligns with the service’s contracts for long term and short term care. |
| 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 fed back to pharmacy. Registered nurses, enrolled nurses and senior caregivers 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. Three self-medicating residents (two rest home and one hospital) had been assessed and reviewed by the GP and RN as competent to self-administer.  Twenty-one charts (12 hospital and nine rest home) medication charts were reviewed on the electronic medication system. One respite care chart was reviewed. All medication charts reviewed have ‘as needed’ medications prescribed with an indication for use. The effectiveness of ‘as required’ medications are entered into the electronic medication system. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All food and baking is prepared and cooked on-site. The qualified chef is supported by cook and kitchen assistants. All staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with the company chef 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, vegetarian 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 and recorded. All foods were date labelled. A cleaning schedule is maintained. The chef maintains regular contact with residents and serves meals to residents in the dining room. 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/whanau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care. |
| 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 (link 1.3.3.3) that were 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 reviewed 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 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 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 family members 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 are updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections.  Wound assessments, treatment and evaluations were in place for minor wounds, two chronic ulcers and three pressure injuries. Adequate dressing supplies were sighted in the treatment rooms. The wound care champion for the service provides advice and support to RNs and reviews wounds weekly. She has access to the DHB wound nurse as required. There is evidence of wound nurse involvement in the care and management of pressure injuries and chronic wounds. Pressure injuries and chronic wounds are linked to the long-term care plans.  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, neurological observations post unwitnessed falls or identified head injuries, 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 Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is a team of four activities coordinators and a weekend activity assistant to deliver the Engage programme across the rest home and hospital areas and serviced apartments. The team is supported by a lifestyle manager at head office. Activity coordinators attend on-site and organisational in-service relevant to their roles. All have current first aid certificates.  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 apartments attend either the serviced apartment programme. There are adequate resources available. Residents receive programmes in their rooms. Daily contact is made with residents who choose not to be involved in the activity programme. There is a men’s group.  Regular interdenominational church services are held on-site.  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 ten care plans had been evaluated by registered nurses’ six monthly. Four residents had not been at the service six months and the other resident was in for respite care. Written evaluations describe the resident’s progress against the residents identified goals. The multidisciplinary review involves the RN, GP, activities staff and resident/family and other allied health professionals involved in the care of the resident. 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 had been 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 referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Ryman specialists, nurse specialists, hospice 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 are implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are 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. Staff have attended chemical safety training. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 1 August 2016.  The facility employs a full-time maintenance person who has completed the site safety course and attends health and safety committee meetings. 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.  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.  Environmental improvements include the replacement of radiator heating units in all corridors and ongoing refurbishment including carpets and painting. External landscaping includes re-forming the “red” (for low vision residents) pathway, new seating for rest areas in the gardens and remodelling of the mini golf area.  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 Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms are single occupancy and have full ensuites. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents’ rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The ground floor of the care centre has the rest home/dual purpose beds and serviced apartments. The first floor is the hospital beds. Each floor has a large main lounge and smaller library lounge and a room for visitors with tea making facilities. The large main lounges have seating placed to allow for individual or group activities. The rest home dining room is adjacent to the kitchen. The hospital dining room extends to a lounge area where residents requiring additional assistance can be fed. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | 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.  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. |
| 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 radiator heating. Heaters in rooms can be individually thermostat controlled. All rooms have external windows with plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection prevention and control programme is appropriate for the size and complexity of the service. 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 and reported to the governing body. Infection control objectives for 2016 reflect the outcomes of surveillance and quality data. The rest home coordinator/RN and clinical manager/RN share the responsibility for infection prevention and control at the facility.  Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine with 80% of residents receiving the vaccine for 2016. Staff are offered the influenza vaccine. There are adequate hand sanitisers throughout the facility. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control committee (combined with the health and safety committee), is made up of a cross section of staff from areas of the service. Both infection control officers have completed annual infection control and prevention training within the DHB, online training and external courses. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GPs, local laboratory and expertise from within the organisation. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There were comprehensive infection prevention and control policies that were current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the 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 and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officers complete 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 officers use 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.  A norovirus outbreak July 2015 was well managed and included a debrief meeting to review overall management by staff. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. On the day of audit there were three hospital residents using four enablers (three bedrails and one lap belt). There were six residents (two hospital level and four rest home level) with restraints (three with bedrails and three chair briefs). Three 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. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The hospital unit coordinator 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. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, approval group, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form was completed for the six 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 100% 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Four of ten (two rest home and two hospital) long-term resident files reviewed had been admitted within the last 10 months. Initial assessments and long-term care plans had been completed within the required timeframes. Two of the four resident files reviewed (one rest home and one hospital) had an interRAI assessment completed within 21 days of admission. | Two of four resident files reviewed (one rest home and one hospital) of residents admitted within the last 10 months did not have an interRAI assessment completed within 21 days of admission. | Ensure all new admissions have an interRAI assessment completed within 21 days of admission.  90 days |

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

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

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

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

|  |  |  |  |
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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The service identified in 2014 an opportunity to increase education and support around end of life care/palliative care for staff. Regular evaluations from staff evidence the staff feel more comfortable in providing holistic end of life care. Relatives have provided positive feedback on the palliative care services at Ngaio Marsh including increased staff confidence and consistency of care, improved and open communication and supportive environment. Ryman completed an evaluation of the project which identified that the reputation of the facility has increased as the best provider for palliative care for residents and their families. There is documented evidence of increase in referral with 21 in 2014, 28 in 2015 and 7 referrals to date for 2016. | The service completed a quality project around palliative care. They completed a clinical review on past files of palliative care residents and feedback sought from relatives on their experience of the service and areas for improvement. Consultation meetings were held including all stakeholders such as management, GP, village residents, residents and hospice educators. An education plan was developed that included care staff attending the palliative care modules. All RNs completed syringe driver training. Care staff who have completed the palliative care course work alongside the RNs. Family meetings are held with the GP, hospice team and RN as soon as a resident requires palliative care to discuss end of life care and wishes. Palliative care kits have been created which provide a calm and peaceful physical environment. Improved proactive prescribing ensures optimal pain management is in place. Additional specific equipment (air alternating mattresses and syringe drivers) were purchased to meet the increasing number of palliative care referrals. Debrief sessions are held for staff following the loss of residents. An evaluation process identified that the service has been successful in providing holistic end of life care for its palliative care residents. Cards and letters viewed on the day of audit including one relative interview evidenced positive feedback from relatives. |
| Criterion 1.2.3.6  Quality 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, analysis 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 2016 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. For the period 1/4/15 to 31/3/16 the falls rate was 7.19 falls per 1000 bed nights for the hospital and 8.17 falls per 1000 bed nights for the rest home. Nagai Marsh rank 3rd out of 26 Ryman Healthcare villages for the hospital and 5th out of 26 villages for the rest home. |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | The service identified a need to maintain resident’s enjoyment with the dining experience and satisfaction with the meals. A project was commenced in December 2014 to review the menu in consultation with the hospitality manager, head chef, management and residents. | A project was commenced in December 2014 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 chef’s choice was implemented based on what residents prefer. A second tea option was introduced. A food comment book is located in each 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. Improvement of the dining experienced included a review of the dining room décor and furnishings. 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. |
| Criterion 1.4.6.2  The 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. A continuous improvement project was commenced in December 2014 to increase resident and relative satisfaction with laundry services. Missing/lost clothing items had been identified as a resident/relative concern in resident surveys and resident meetings. | A continuous improvement project was commenced in December 2014 to increase resident and relative satisfaction with laundry services. Missing/lost clothing items had been identified as a resident/relative concern in resident surveys and resident meetings. Each resident was provided with individually labelled laundry bags for their personal clothing. The 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. The labelling of clothes is now incorporated into the shift due to the reduced number of clothes requiring labels.  The laundry staff keep a daily record of any unlabelled clothing items. The log book (reviewed) evidences very few unlabelled items being received in the laundry such as handkerchiefs. Resident/relative interviews on the day of audit confirmed there has been a marked reduction in the number of missing personal clothing and they were very satisfied with the laundry service. A visit to the laundry on the day of audit demonstrated evidence of the system being implemented with a small amount of clothing un-named. |

End of the report.