

Ryman Napier Limited - Princess Alexandra 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](#).

The specifics of this audit included:

Legal entity:	Ryman Napier Limited
Premises audited:	Princess Alexandra Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 July 2016 End date: 5 July 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:	104

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

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

General overview of the audit

Princess Alexandra is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia level of care for up to 108 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 104 residents in the care centre and 9 residents in the serviced apartments. An experienced village manager who is a registered nurse and an experienced clinical manager who is also a registered nurse manage the service. The residents and relatives interviewed spoke positively about the care and support provided.

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

This audit identified that no improvements are required.

Areas of continuous improvements were identified around reduction of falls incidence for hospital residents, and the laundry service.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Princess Alexandra provides care in a way that focuses on the individual resident's quality of life. There is a Māori health plan and implemented policy supporting practice. Cultural assessments are undertaken on admission and during the review process. Policies are being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents and families. Care plans reviewed accommodated the choices of residents and/or their family. Complaint processes are being implemented and complaints and concerns are managed appropriately. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

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

education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligned with contractual requirements and included skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete routine InterRAI assessments, risk assessments, care plans, interventions and evaluations. 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 rest home, hospital and dementia care residents including men's group, entertainment and community outings.

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. There are nutritious snacks available at all times in the dementia unit.

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.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with ensuites in the rest home and hospital rooms. There are adequate numbers of communal shower/toilets in the dementia care unit. 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.
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There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The clinical manager/restraint coordinator oversees restraint/enabler usage within the facility. The service currently has two residents using restraints and three residents voluntarily using enablers. The restraint coordinator maintains a register. The restraint approval committee reviewed restraint use. Staff regularly receive education and training in restraint minimisation and managing behaviours that challenge.

Infection prevention and control

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

Standards applicable to this service fully attained.

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	0	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Three families (one hospital and two dementia care) and nine residents (four rest home and five hospital) interviewed, stated they were provided with information on admission which included the Code. Interview with six care assistants (two rest home, three hospital and one dementia care) demonstrated an understanding of the Code. Residents and relatives confirm staff respect privacy and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. General consents (incorporated in the admission agreement) and specific consents reviewed in 11 resident files, were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives were signed-for separately. There was documented evidence of discussion with the next of kin/EPOA where the resident was deemed incompetent to make a decision regarding resuscitation.</p> <p>Copies of EPOA are kept on the residents file where required. Care assistants and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family</p>

		<p>members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten long-term resident files reviewed have signed admission agreements. The resident on intermediate care contract had signed a short-term agreement.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at Princess Alexandra. 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 10 complaints made in 2015 and 6 complaints made 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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Residents and relatives confirmed information had been provided around the Code. Large print posters of the Code and advocacy information were displayed throughout the facility. The village manager reported having an open door policy and described discussing the information pack with residents/relatives on admission. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>

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

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Ryman Healthcare has a teamRyman programme that includes annual planning and a suite of policies/procedures. Policies are reviewed at an organisational level. These documents have been developed in line with current accepted best practice, and are reviewed regularly. Services are provided at Princess Alexandra that adhere to the health and disability services standards. An implemented quality improvement programme includes performance monitoring.</p> <p>There are human resources policies/procedures to guide practice and an annual in-service education programme that is incorporated into the teamRyman programme. There is evidence at Princess Alexandra 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 care assistants and qualified nurses. Core competency assessments and induction programmes are being implemented at Princess Alexandra. Registered nurses have access to external training. Residents and relatives interviewed were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Incidents reviewed on the VCare system met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. Resident and relative meetings are held regularly. There was an interpreter policy and contact details of interpreters were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Princess Alexandra Retirement Village is a Ryman Healthcare facility, situated in Napier. The service is able to provide care for up to 108 residents in the care centre at hospital, rest home and dementia level care. There are also 30 serviced apartments certified to provide rest home level of care. Sixty beds within the care centre are dual-purpose. There were 104 residents in the care centre and 9 rest home residents in the serviced apartments. The care centre residents included 22 rest home (none in dual-purpose beds), 57 hospital residents (all in dual-purpose beds), and one hospital resident on a short-term medical contract. There were 24 residents in the dementia unit.</p> <p>There were no rest home residents in the hospital wing. All long-term residents were under the ARC agreement.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Quality objectives for the 2015 year have been reviewed and 2016 objectives are in place. There is a health and safety, and risk management programme being implemented at Princess Alexandra.</p>

		<p>The village manager is a registered nurse who has been in this role for eight months. Prior to this appointment, she was a clinical nurse manager and clinical practice manager for respiratory services. A full-time clinical manager supports the village manager. The clinical manager has been in the position for one month and has over 20 years' experience as an RN. Unit coordinators in each area and clinical advisors at head office, support the managers. Management are supported by a regional operations manager and clinical practice and audit manager (at head office).</p> <p>The village manager has completed the Ryman leadership programme, six monthly study days and recruitment course training in May 2016. The clinical manager has completed ongoing training via the orientation/induction programme, RN modules and in-service programme.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Ryman policy outlines manager availability, including on call requirements. During a temporary absence, the assistant manager and clinical manager will cover the village manager's role. The assistant manager covers administrative functions and the clinical manager covers clinical care. The regional operations manager provides oversight and support.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Princess Alexandra service continues to implement the teamRyman Programme, which links key components of the quality management system to village operations. There are monthly full facility teamRyman meetings conducted. Outcomes from the teamRyman committee are then reported across the various meetings, including the full facility, RN and care assistant meetings. Meeting minutes include discussion about the key components of the quality programme including policy reviews, internal audit, training, complaints, accidents/incidents, infection control and quality improvement plans (QIPs). Management meetings are held weekly. Health and safety, and infection control meetings are held three monthly. Clinical meeting minutes were sighted. Interviews with staff confirmed an understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence. Care staff stated they are made aware of any new/reviewed policies and these are available in the staff room.</p> <p>Relative survey was last completed in March 2016 and resident survey in February 2016. Results have been collated with annual comparisons for each service. Areas of concern have been identified</p>

		<p>and quality improvement plans raised (QIPs) and these have been completed and signed off. Results have been fed back to participants through resident and relative meetings. TeamRyman develops the annual internal audit schedule that has been implemented at Princess Alexandra. Internal audit summaries and QIPs are completed where a non-compliance is identified (<90%). Issues and outcomes are reported to the appropriate committee (eg, health and safety). QIPs reviewed are seen to have been closed-out once resolved.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets (eg, falls). Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The combined health and safety and infection control committee meet bi-monthly and incidents/accidents and infections are discussed and documented. There is a current hazard register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Princess Alexandra 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 is used for comparative purposes. QIPs have been created when the number of incidents exceeded the benchmark. Fourteen accident/incident forms reviewed (four rest home, six hospital and four dementia care) identified timely RN assessment and post falls assessments where required. Quality improvement plans (QIPs) were seen to have been actioned and closed-out.</p> <p>Management were aware of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 incident notification forms were completed, one in 2015 (outbreak) and two in 2016 (police investigation and outbreak). The appropriate action has been taken in relation to the police matter outlined in the mandatory notification that was sighted. Notifications to relevant personnel were sighted for an outbreak in January 2015 and June 2016.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are job descriptions for designated officers. Appropriate recruitment documentation was seen in the 13 staff files (one clinical manager, one assistant manager, on activities coordinator, one maintenance, one chef, one laundry, one housekeeper, one enrolled nurse, two RNs and three care assistants) 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</p>

		<p>current practising certificates is maintained.</p> <p>There is an annual training plan aligned with the teamRyman programme that was being implemented. Staff 'catch up' folders contain education content for staff to read and sign if they were unable to attend training. Ryman ensures RNs are supported to maintain their professional competency including attending the journal club meetings and completing InterRAI training through the Ryman programme. Six of fourteen RNs (including the clinical manager) have completed their InterRAI training. Six of thirteen care assistants who are employed in the dementia care unit have completed their dementia standards. Seven of seven care assistants that have not completed the unit standards have commenced work in the last 12 months. All seven were in progress of completing their dementia standards. Completion of the induction programme and required dementia standards are monitored and reported monthly to head office, as part of the teamRyman programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Ryman organisational policy outlines on-call requirements, skill mix, staffing ratios and rostering for facilities. A fulltime clinical manager oversees the care centre. Each unit in the care centre has a RN unit coordinator. There is at least one RN and first aid trained member of staff on every shift. There is a full time serviced apartment unit coordinator (RN), and hospital care staff oversee the serviced apartments at night. Interviews with care assistants informed the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. Agency staff can be used to cover unexpected absences. The village manager and clinical manager (both RNs), work full time and are on call 24/7; they share an on call roster with the unit coordinators.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in a locked cupboard in both areas. Care plans and notes were legible and where necessary signed (and dated) by a RN. Entries reviewed were legible, dated and signed by the relevant care assistant or RN including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent,</p>	FA	<p>There are policies and procedures to guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. The relatives interviewed stated</p>

<p>equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The information pack contains specific information relating to dementia level of care.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term and short-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with medication regulations and guidelines. Medication reconciliation is completed by RNs on delivery of medication and any errors fed back to pharmacy. Registered nurses and enrolled nurses who administer medications have been assessed for competency on an annual basis. Qualified staff interviewed, were able to describe their role concerning medicine administration. Senior care assistants complete a medication competency to check medications. Education around safe medication administration has been provided. Medications were stored safely. All eye drops were dated on opening. Medication fridges were monitored weekly.</p> <p>Standing orders are not used. Two self-medicating residents (one rest home and one hospital) had been assessed and reviewed by the GP and RN as competent to self-administer.</p> <p>Twenty-one medication charts (nine hospital, six rest home and six dementia care) were reviewed on the electronic medication system. One intermediate care medication chart was reviewed. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications are entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component</p>	<p>FA</p>	<p>All food and baking is prepared and cooked on-site. Cook assistants and kitchen assistants support the qualified head chef. All staff have been trained in food and chemical safety. The dietitian at organisational level had reviewed a four-weekly seasonal menu. There is flexibility to amend the menu to meet the resident's preferences. Meals are transported in hot boxes to the unit kitchenettes. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes</p>

<p>of service delivery.</p>		<p>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, lactose and dairy free are provided.</p> <p>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 chemical provider monitors the dishwashers monthly. The chef maintains regular contact with residents in the dining room. Feedback on the service is received from daily resident contact, resident meetings, surveys and audits and the food comment book in the dining room.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Risk assessments have been completed on admission and reviewed six monthly as part of the evaluation process. The outcomes of routine InterRAI assessments and risk assessments triggered were reflected in the care plans reviewed. InterRAI assessments had been completed for all permanent residents. 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.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>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. The care plans for dementia care residents include behaviours, triggers and interventions including activities over a 24-hour period. 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</p>

		reviews.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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.</p> <p>Wound assessments, treatment and evaluations were in place for 16 residents with wounds, one resident with a chronic ulcer and one hospital resident with a stage-one pressure injury. Adequate dressing supplies were sighted in the treatment rooms. The wound care champion (hospital RN) for the service provides advice and support to RNs and reviews wounds regularly. Pressure injuries and chronic wounds are linked to the long-term care plans. Registered nurses have attended pressure injury prevention and wound care education.</p> <p>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 the clinical manager could describe this.</p> <p>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.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is a team of two diversional therapists (DT) and activities coordinators (including weekend activity staff and an on-call DT) to deliver the Engage programme across the rest home, hospital and dementia care units. A lifestyle manager at head office supports the team. Activity staff attend on-site and organisational in-service relevant to their roles. All activities staff have current first aid certificates.</p> <p>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 a rest home programme in the serviced apartments. The programme is from Monday to Friday in the rest home and seven days a week in the hospital and dementia care units. Additional activity hours are provided in the hospital unit for one-on-one time with individual residents. Head office initiates monthly themes. Triple A exercise programmes in each unit meet the physical abilities of the residents. There are townhouse volunteers involved in the men's group.</p>

		<p>Community visitors to the service include pre-school children, entertainers, RSA visitors and pet therapy. There are regular visits into the community including concerts and outings and drives. A mobility van is hired weekly for hospital resident outings.</p> <p>There are adequate resources available. Daily contact and individual activities are provided for residents who choose not to be involved in the activity programme.</p> <p>Regular interdenominational church services are held on site.</p> <p>Resident life experiences and 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/relative meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Eight of eleven care plans had been evaluated six monthly, by registered nurses. Two residents had not been at the service six months and the other resident was in for intermediate 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.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access with 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 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 or contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were readily available in the</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>sluice rooms. 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 datasheets and product use information was readily available. Staff have attended chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires on 1 August 2016.</p> <p>The facility employs a full-time maintenance person who has completed a health and safety, first aid and chemical safety course. The maintenance person ensures daily maintenance requests are addressed. A 12-monthly planned maintenance schedule has been signed off monthly as completed (sighted). Essential contractors are available 24-hours. Electrical testing has been completed. Kitchen and laundry equipment is serviced twice yearly. An external contractor completes annual calibration and functional checks of medical equipment, hoists and electric beds. Rooms are refurbished as they become vacant.</p> <p>Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>There is safe access to the external courtyard and walking pathway for residents in the dementia care unit.</p> <p>The care assistants and RNs interviewed stated they have sufficient equipment to deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All bedrooms are single occupancy. The bedrooms in the rest home and hospital all have full ensuites. The bedrooms in the dementia care unit do not have ensuites. There were adequate numbers of communal shower/toilet and handwashing facilities in the dementia care unit. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All resident's 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 as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The care centre including the dementia unit is on the ground floor. Each unit has a large main lounge and smaller family room/lounge. The large main lounges have seating placed to allow for individual or group activities. Each unit has a dining/kitchenette area. Activities take place in the lounges of each unit. All areas are accessible. Care staff assist residents to communal areas as required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the Ryman programme. The laundry had an entry and exit door with defined clean/dirty areas.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner. The service has been awarded a continuous improvement rating for the labelling process that has reduced the number of missing clothing items.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and cardiopulmonary resuscitation (CPR) are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The village has an approved fire evacuation plan. Fire drills occur six monthly. The service has an emergency generator onsite, gas barbeque and cylinders, sufficient water and food in the event of an emergency. Emergency lighting is in place. An electronic call-bell system was evident in all residents' rooms and ensuites, communal toilets and communal lounge and dining areas. The building is secure after hours. The dementia care unit has secure access.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately ventilated and heated with underfloor heating. Residents have panel heaters in their rooms that can be individually thermostat controlled. Heat pumps have been installed in communal areas. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>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 is directed via the quality programme. The programme is reviewed annually and a six-month analysis is completed and reported to the governing body. The clinical manager is the infection control officer for the facility.</p> <p>Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine. Staff are also offered the influenza vaccine. There are sufficient hand sanitisers throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control committee (combined with the health and safety committee), is made up of a cross section of staff from areas of the service. The infection control officer has been in the role three weeks and is in the process of completing the infection control coordinator induction, and has completed on line MOH training. 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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflect the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection 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. Registered nurses also complete annual infection control education as part of the RN journal club. 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 coordinator 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 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. A confirmed norovirus outbreak January 2015 was well managed and included a debrief meeting to review overall management by staff. Relevant authorities had been notified.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The organisation is working towards becoming restraint-free. During the audit, there were three residents using enablers (bedrails) and two residents with restraints (bedrails). Three resident files were reviewed where an enabler (bedrails)

		was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed. Staff training is in place around restraint minimisation and management of challenging behaviours.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	The rest home unit coordinator is the restraint coordinator for the facility, and they have defined responsibilities included in the job description. The restraint approval committee meets six monthly. There is ongoing restraint education including challenging behaviours. Quality and clinical meetings include discussion on restraint. Staff carry out and record restraint monitoring including cares delivered during the restraint period.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	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 two residents requiring restraint (sighted). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	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.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of</p>	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.

restraint.		
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>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.</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Robust systems are in place for the collection, analysis and evaluations of quality data. A range of data is collected across the service using VCare, 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 (eg, management meetings, full facility meetings, clinical meetings). Data collated is used to identify any areas that require improvement. The quality programme for 2016 includes objectives for improving outcomes for</p>	<p>Falls rate for hospital residents had been identified as an area that required improvement from data collected from January 2014 - January 2015. The rate had been above the reference range of 11 falls per 1000 occupied bed days (15).</p> <p>A plan was developed as part of their 2015 and 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 service has implemented a traffic light system, which indicates the level of supervision required for the resident. The colour coded traffic light system is individualised</p>

		<p>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</p>	<p>and on display in the resident rooms. Mobility aids have a corresponding colour coded 'flag' on their mobility aid. The system was evidenced in several rooms viewed on the day of audit and on mobility aids in use. The physiotherapist and physiotherapist aide (interviewed) confirmed they were actively involved in mobility assessments and exercise programmes for residents for the prevention of falls. The effectiveness of the falls prevention plan has been reviewed monthly and discussed at staff meetings. Education and training for staff has been regularly provided.</p> <p>Evaluation of the falls reduction programme has identified that the rate of falls for hospital residents has been reported as under the target rate of 11, having reduced to 6.8 per 1000 occupied bed days. This has remained under the reference range limit for year to date in 2016. Princess Alexandra is now ranked number 2 out of 25 Ryman villages for the lowest falls rate.</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	CI	<p>A continuous improvement project commenced in January 2015, to increase resident and relative satisfaction with laundry services.</p>	<p>Missing/lost clothing items had been identified as a resident/relative concern in resident surveys and resident meetings.</p> <p>The service devised a system whereby 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.</p> <p>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 box of un-named clothing.</p>

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End of the report.