

Grace Joel Retirement Village Limited - Grace Joel 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:	Grace Joel Retirement Village Limited
Premises audited:	Grace Joel 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: 6 October 2016 End date: 7 October 2016
Proposed changes to current services (if any):	One lounge in the rest home wing and one lounge in the hospital wing were assessed as suitable for dual-purpose rooms. This increases the total beds available to 129.

Total beds occupied across all premises included in the audit on the first day of the audit: 106

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

Grace Joel is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home and hospital (medical and geriatric) level care for up to 99 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 106 residents including six rest home residents and one respite care resident in the serviced apartments. The service is managed by an experienced non-clinical village manager, assistant 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.

The service was fully compliant at this certification audit.

Areas of continuous improvements were identified around good practice, falls reduction, activities, laundry service and infection surveillance.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori Health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints.

Organisational management

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager, assistant village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular

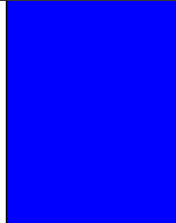
reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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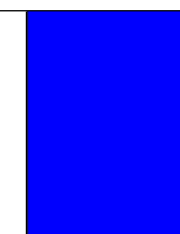
There is a comprehensive information package for residents/relatives on admission to the service. InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed 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 and ladies 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.

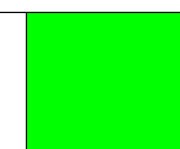
The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated.

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.
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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. Two lounges have been converted to dual-purpose rooms with separate bathrooms. 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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint and four residents with enablers at the time of audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

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

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team 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.

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	4	41	0	0	0	0	0
Criteria	5	88	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
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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one village manager, one assistant village manager, one clinical manager) and twenty-three staff (two staff registered nurses (RNs), one hospital coordinator/RN, one rest home coordinator/RN, one enrolled nurse (EN), six care assistants, seven activities staff, two laundry, one cleaner, one chef, one property manager) described how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.
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	FA	Informed consent processes are discussed with residents and families on admission. Written general consents and resuscitation status were completed in 10 of 10 resident files reviewed (five hospital including one hospital level resident under palliative care contract and one hospital resident in rest home wing, five rest home level of care residents including one rest home resident in the hospital wing, one in the serviced apartments and one rest home respite care resident). Advanced directives are signed for separately. Copies of EPOA are kept on the residents file where required. Care assistants and registered nurses (RN) interviewed, confirmed verbal consent is obtained

<p>informed consent.</p>		<p>when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Nine resident files reviewed have signed admission agreements for long-term care and the respite care resident has 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>	<p>FA</p>	<p>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/enduring power of attorney (EPOA) to be involved in decisions. The residents' 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>	<p>FA</p>	<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. Interviews with staff, residents and relatives confirmed 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>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available on each floor. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. All complaints received in 2016 (six hospital level and eight rest home level) were documented as resolved. Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	<p>FA</p>	<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. Four relatives (one rest home, three hospital) and ten residents (six rest home with one in a serviced apartment, four hospital) stated they were provided with information on admission which included the Code. Large print posters of the Code and</p>

rights.		advocacy information are displayed throughout the facility. The village manager reported having an open-door policy and described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ryman has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while cares were being done.</p> <p>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. Instructions are provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Care assistants interviewed described how choice is incorporated into resident cares. Staff attend education and 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. There were no residents who identified as Māori at the time of the audit.</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 family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited and encouraged to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their cultural values.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data are collected against each service level, and reported through to Ryman Christchurch (formerly known as head office) for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman programme (previously known as Ryman Accreditation Programme RAP). Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. The system of data analysis and trend reporting is designed to inform staff at the facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.</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>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arises. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Fifteen incident/accident forms and corresponding residents' files were reviewed and all identified that the next of kin were contacted. Regular resident and family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. There were four residents with English as their second language. Family and staff are able to</p>

		interpret. Signage is in the rooms to assist with simple words.
<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>	FA	<p>Grace Joel is a Ryman healthcare retirement village located in St Heliers, Auckland. They are certified to provide rest home and hospital (medical and geriatric) level care in their care centre for up to 97 residents. There are also 30 serviced apartments certified to provide rest home level care. Occupancy during the audit was 29 rest home level residents and 70 hospital level residents in the care facility, and 7 rest home level residents in the serviced apartments. Resident numbers included one resident receiving palliative care under the medical component of the hospital certification and one rest home level respite resident. Two lounges had been temporarily converted to dual-purpose rooms to accommodate overflow. There were resident's in each of these two temporary lounges, which has increased resident numbers to 99 in the care centre. This audit also included verifying these two rooms as suitable to provide rest home or hospital level care. The floors are a mirror image of each other. There are two lounges and separate dining room, this does not include the smallest lounge converted to a bedroom on each floor.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2016 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been in his role for two years. He has an accounting background. He has attended over eight hours (year to date) of professional development activities related to managing an aged care facility.</p> <p>The village manager is supported by a regional manager, an assistant village manager and a clinical manager/RN.</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>The clinical manager and assistant village manager are responsible during the temporary absence of the village manager, with support from the regional manager.</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>	<p>FA</p>	<p>Grace Joel has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff, and review of management and staff meeting minutes, demonstrate their involvement in quality and risk activities.</p> <p>Resident meetings are held two monthly. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings that also include review of infection control and of incidents. A health and safety officer is appointed who has completed health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice. The hazard identification resolution plan is sent to head office, and identifies any key hazards that are identified. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place. The service has achieved a continuous improvement in relation to falls reduction.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including</p>

<p>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>		<p>immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of incident/accident forms for 2016 identifies that all are fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities. Notifications to the relevant authorities were sighted for two outbreaks (March and April 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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (the assistant village manager, nine care assistants, one registered nurse, one receptionist, one enrolled nurse) included a signed contract, job description relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice (link to CI 1.1.8.1). It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Evaluations are completed for all training provided. Registered nurses are supported to maintain their professional competency. Seven registered nurses have completed their InterRAI training, meeting contractual requirements. Staff training records are maintained. There are implemented competencies for registered nurses and care assistants related to specialised procedure or treatment including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. There is a minimum of three RNs (or two RNs and one EN) and five care assistants on site at any time. Activities are provided seven days a week in the hospital. A minimum of one staff member is on duty in the serviced apartments 24/7.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner</p>

and/or experienced service providers.		as confirmed by all residents interviewed (link to CI 1.1.8.1). Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded 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 are protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy. Information gathered on admission is retained in residents' records. 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	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 RNs on delivery of medication and any errors fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants 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. All eye

guidelines.		<p>drops and cream were dated on opening.</p> <p>Standing orders are not used. One self-medicating rest home resident had been assessed and reviewed by the GP and RN as competent to self-administer.</p> <p>Twenty charts (10 hospital and 10 rest home) medication charts were reviewed on the electronic medication system. 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 of service delivery.</p>	FA	<p>All food and baking is prepared and cooked on-site. The qualified head chef is supported by a weekend chef and kitchen assistants. 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 dietitian at organisational level.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as pureed/soft, diabetic desserts and gluten 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 chef maintains regular contact with residents and addresses any comments in the suggestion book in each 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>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential 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 Consumers' needs, support requirements, and preferences</p>	FA	<p>The facility has embedded the InterRAI assessments within its clinical practice. Risk assessments have been completed on admission and reviewed six monthly as part of the evaluation process. The outcomes of InterRAI assessments and risk assessments triggered were reflected in the care plans reviewed. Additional assessments such as behavioural, wound and restraints were completed according</p>

<p>are gathered and recorded in a timely manner.</p>		<p>to need. In the resident files reviewed the outcomes of all assessments, needs and supports required were reflected in the initial nursing assessment care plan and long-term care plans.</p>
<p>Standard 1.3.5: Planning 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 for long term and short term residents. 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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<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 17 residents with wounds (skin tears and two residents with chronic ulcers). There were no pressure injuries on the day of audit. Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse as required. There is evidence of wound nurse and specialist involvement in the care and management of chronic wounds. Chronic wounds are linked to the long-term care plans.</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 this could be described by the RNs interviewed.</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 Where specified as part of the service delivery plan for a</p>	<p>CI</p>	<p>There is a team of seven activities staff (five coordinators, qualified diversional therapist (DT) and one DT in training. The team implement the 'Engage programme' across the rest home, hospital and serviced apartments. Activity staff attend on-site and organisational in-service relevant to their roles. All staff have current first aid certificates.</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</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 either 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. Residents are encouraged to participate in activities across the village. There are a number of volunteers including village friends, duke of Edinburgh students and gateway programme for college students. Community involvement includes entertainers, church services, community outings and shopping.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. The survey has been successful in implementing the Engage programme and can evidence increased resident and relative satisfaction with activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans had been evaluated by registered nurses for five long-term residents who had been at the service six months (one hospital and four rest home residents). Three hospital residents and one palliative care had not been at the service six months. One rest home resident was respite care. Written evaluations for long-term residents who had been at the service six months describe the resident's progress against the resident's identified goals. The multidisciplinary review includes the 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. The multidisciplinary review involves the RN, clinical manager, GP, care assistant and activities staff</p>
<p>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</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was 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.</p>

choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	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 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 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>	FA	<p>The building has a current building warrant of fitness that expires 13 November 2017.</p> <p>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 and part-time team ensures daily maintenance requests are addressed and maintains a 12-monthly planned maintenance schedule. 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.</p> <p>Hot water temperatures in resident areas are monitored three monthly as part of the internal audit schedule. Corrective action has been taken and documented where temperatures have been outside of the acceptable range.</p> <p>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.</p> <p>Environmental improvements include the replacement of high-low beds to electric beds, ongoing refurbishment including carpets and painting, refurbishment of bedrooms as they become vacant, refurbishment of the serviced apartments and improved lighting, windows have been re-sealed and exterior cladding replaced. The caregivers and RNs interviewed stated they have sufficient equipment to safely 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</p>	FA	<p>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. There is a separate shower and toilet/bathroom</p>

<p>adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>next to the two lounges that have been converted to bedrooms.</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 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. The two lounges converted to bedrooms (one in the rest home and one in the hospital) are spacious and allow for the use of hoists and other mobility aids. There is sufficient space to accommodate relatives who wish to stay overnight.</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 first floor of the care centre has the rest home/dual-purpose beds and serviced apartments. The second floor is the hospital/dual-purpose beds and serviced apartments. Each floor has a large main lounge, smaller lounge and a central separate dining area. The large main lounges have seating placed to allow for individual or group activities. There is safe access to communal areas for residents who mobilise with mobility aids and for the transfer of residents on lazy boy chairs with wheels.</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>CI</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 has defined clean/dirty areas with entry and exit doors.</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 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 and fire drills take place six monthly. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting and cooking facilities are in place. There are civil defence kits in the facility and stored water on site. The call bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms. Call bells were also evident in the rooms and toilets for the two lounges that had been converted temporarily to hospital level rooms.</p> <p>Serviced apartments have a call bell system, which is linked to staff pagers, and to the call bell panels in the rest home. Staff advise that they conduct security checks at night, in addition to an external contractor.</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>	<p>FA</p>	<p>General living areas and resident rooms are appropriately ventilated and heated. 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>	<p>FA</p>	<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 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. A registered nurse is the infection prevention and control officer at the facility.</p> <p>Visitors are asked not to visit if they are unwell. Residents are offered the annual influenza vaccine. Staff are offered the influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	<p>FA</p>	<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 and prevention officer has completed the on-line MOH infection control and prevention course and participates in the annual Ryman</p>

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		teleconference and training last held July 2016. 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>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	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.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection prevention and control officer is responsible for coordinating and 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 six monthly as part of the training schedule. Additional topical in-service is held at handovers. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	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 officer completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. Meeting minutes are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. 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.

		There have been two norovirus outbreaks in March 2016 (negative results) and in April 2016 (positive result). Appropriate documentation including notifications to relevant authorities were sighted including 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	Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint and four using enablers. The facility has been restraint-free for three years (link to CI 1.1.8.1). Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.

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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service provides an environment that encourages good practice, which is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings. There is evidence of action taken based on findings that have resulted in improvements to service provision. The projects include reviewing whether improvements have had positive impacts on resident safety or resident satisfaction.</p>	<p>A number of quality initiatives have been implemented including reducing the number of call bells not answered within a target timeframe; maintaining a restraint free environment; and creating a welcoming and structured orientation process for new staff.</p> <p>Initially in 2016, Grace Joel had the highest number of calls throughout the first six-monthly period and had the fourth lowest number of missed calls (greater than 10 minutes to respond) in the group. An action plan to improve call bell response times was implemented and included reviewing the call bell system, replacing faulty pagers, analysing data, targeting actions for those who have not had their bells answered within the target timeframe, and meeting with staff (meetings, handovers). For the second six-month period (March-August 2016) they had an improvement of results. Whilst they still had the highest number of calls overall, they had the second lowest number of missed calls in the Ryman group.</p> <p>The facility has remained restraint free for three consecutive years while continuing to reduce the number of falls. This has been maintained through lengthy discussions with family, staff education, liaising with the restraint</p>

			<p>coordinator, restraint committee and the leisure and lifestyle manager to engage residents in activities throughout the day, implementing falls initiatives (link to CI 1.2.3.6), ensuring that there is adequate supervision in the lounges during evening shifts, GP regularly reviewing medication and the monthly review of the restraint register.</p> <p>On 1 June 2015, the percentage of overall inductions completed was 89%. An action plan was developed focusing on a more comprehensive and welcoming orientation plan. Outcomes of the new orientation process reflected that staff are more confident and competent within their roles. They reported feeling welcomed, supported, confident and competent in their roles. As staff are more confident and competent in their roles, this has improved the quality of care the residents receive. Furthermore, the percentage of completed inductions has risen to 100%.</p>
<p>Criterion 1.2.3.6 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, analyses, and evaluation of quality data. Results are communicated to staff via a variety of forums. A range of data is collected across the service using an electronic data system. Data is collated and analysed with comprehensive evaluation reports completed six monthly. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings (eg, management meetings, full facility meetings, care assistant meetings). Templates for all meetings document action required, timeframe, and the status of the actions.</p>	<p>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 falls, skin tears, pressure injuries, and infections.</p> <p>Falls were identified as an area that required improvement. A plan was developed which included identifying residents at risk of falling, implementing a falls clock to identify when falls are occurring, highlighting residents at risk through a colour coding system, providing falls prevention training for staff, targeting a reduction in 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. Care assistants interviewed were knowledgeable in regards to preventing falls and those residents who were at risk. The plan has been reviewed monthly and discussed at staff meetings. A review of the benchmarking data for the 12-month period ended September 2016 evidences Grace Joel ranks 6th out of 26 villages. The falls rate remains significantly below the limit reference range of 11 falls per 1000 bed nights. Specifically, the hospital unit is 1.5 falls per 1000 bed nights for</p>

			the period and the rest home is 1.3 falls per 1000 bed nights for the period.
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The results from the 2015 resident and relative survey identified there was an improvement required to increase resident/relative satisfaction around activities. The project commenced in June 2015 with a focus on the provision of an interesting and varied programme which encouraged the full village participation and increased attendance and enjoyment of activities. The 2016 resident and relative survey results demonstrate the service has been successful in achieving satisfaction with the Engage programme.</p>	<p>The activity team are supported by management to develop new initiatives, share skills and ideas between the areas and encourage participation of all residents in village activities, such as theme months, events, choir concerts and inter-village bowls. Local schools and groups have become involved in activities. The ladies group and men's group enjoy meaningful and interesting activities and outings. There has been a change from passive to active type activities. Relatives are kept informed on activities and these are showcased at relative meetings. Attendance at Triple AAA exercises have increased from 15.8 (average hospital attendance per day) in July 2015 to 28.2 in September 2016. Rest home attendance at Triple AAA exercises have increased from 16.4 (average rest home attendance per day) in July 2015 to 21.3 in September 2016. The resident survey for hospital residents improved from 3.89 (2015) to 4.33 (2016), which placed Grace Joel in first place for the group. The relative survey results for hospital also showed improvement from 3.8 in 2015 to 4.1 in 2016.</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 was commenced in February 2015 to increase resident and relative satisfaction with laundry services. Missing/lost clothing items had been identified as a resident/relative concern in resident surveys and resident meetings. The service has been successful in reducing the amount of lost/missing clothing items.</p>	<p>Each resident was provided with individually labelled laundry bags for their personal clothing. The purple resident clothing bags were seen in resident ensembles. 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. A visit to the laundry on the day of audit demonstrated evidence of the system being implemented with no unclaimed or un-named clothing.</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. The resident and relative February 2016 survey evidences an increase in satisfaction with the laundry service</p>

			and includes comments such as “a good service”, “this has improved” and “the laundry service at Grace Joel is fantastic”.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. Infections are included on an electronic register and the infection prevention and control officer completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. Meeting minutes are available on the staff noticeboard. The infection prevention and control programme links with the quality programme.</p>	<p>Quality initiatives are implemented when the service is above the benchmark. For example, in February, urinary tract infections (UTIs) for rest home and hospital were above the Ryman benchmark indicator and an action plan was implemented February 2015 to reduce UTIs. The action plan included (but not limited to) a) residents taken to lounges where closer fluid intake monitoring could occur, b) more frequent fluid rounds and providing assistance where needed, c) fluids offered in a variety of forms such as jellies, smoothies and ice blocks, d) fluids offered as part of intentional rounding and e) education of staff included continence management and nutrition and hydration.</p> <p>Urinary tract infections monitored over an 18-month period from February 2015 to September 2016 for hospital residents evidenced UTIs had been below the industry benchmark of 1.5/1000 bed days for 13 of the 18 months. Urinary tract infections monitored over an 18-month period from February 2015 to September 2016 for rest home residents evidenced UTIs had been below the industry benchmark of 1.5/1000 bed days for 12 consecutive months from September 2015 to September 2016 with zero UTIs for the last five months. The service has been successful in reducing the incidence of UTIs</p>

End of the report.