

Jean Sandel Retirement Village Limited

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: Jean Sandel Retirement Village Limited

Premises audited: Jean Sandel 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: 25 October 2018 End date: 26 October 2018

Proposed changes to current services (if any):

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

Jean Sandel is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 112 residents in the care centre and up to 20 residents at rest home level in the serviced apartments. There were 104 residents at the time of the audit including one resident at rest home level of care in the serviced apartments.

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, family, management, staff and a general practitioner.

The village manager is appropriately qualified and has been in the role six months. He is supported by an experienced assistant manager and a clinical manager/registered nurse. The residents and relatives interviewed spoke positively about the care and support provided.

There were no areas identified for improvement at this audit.

Areas of continuous improvements were identified around good practice, quality initiatives and laundry services.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

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

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 and implemented Māori health plan in place. Individual care plans reflect the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an adverse event or has a change in their health condition. Families and friends are able to visit residents at times that meet their needs. There is an established system that is being implemented for the management of complaints.

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.

Services are planned and coordinated, and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A 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 for staff includes in-service education and competency assessments. Registered nursing cover is provided seven days a week and on-call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

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 an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms have ensuites. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. There is an approved fire evacuation scheme. There are six-monthly fire drills. Staff have attended emergency and disaster management. There is a first aider on-site at all times.

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.

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 any restraints and one resident with an enabler at the time of the 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.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	43	0	0	0	0	0
Criteria	3	90	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's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Sixteen care staff (three unit-coordinators, two registered nurses, eight caregivers and three activities coordinators) interviewed, confirmed their understanding of the Code and how it 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 which was last completed in April 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all 11 resident files reviewed (four hospital including one younger person under long-term support chronic health condition funding, four rest home including one respite care and one resident in the serviced apartment and three dementia care resident files). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Advance care plans were available in some files as appropriate. Where a resident was deemed incompetent the general practitioner had made a medically indicated resuscitation status in discussion with the Enduring power of attorney (EPOA). The EPOA had been activated in the three dementia resident files reviewed.

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents 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.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. 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.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. 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. 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. Twenty-two complaints have been received since the last audit (14 made in 2018 [YTD] and eight in 2017). All complaints have been managed in a timely manner and are documented as resolved.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Five relatives (one rest home, two hospital and two dementia) and six residents (five rest home and one hospital) interviewed, confirmed that they have been provided with information on the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager and clinical manager reported having an open-door policy and described the process around 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.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the 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. 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. Caregivers interviewed described how choice is incorporated into residents' cares. Staff attend education and training on abuse and neglect last occurring in June 2018.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Links are established with local iwi and other community representative groups as requested by the resident/family. Family/whānau involvement in assessment and care planning and visiting is encouraged. There was one resident (dementia level) who identified as Māori at the time of the audit but was unable to be interviewed. Cultural needs were identified both in the interRAI assessment and in the resident's care plan. Family/whānau input was sought in the resident's care planning process.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or 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, and that staff take into account their cultural values.
Standard 1.1.7: Discrimination Consumers are free from any	FA	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

discrimination, coercion, harassment, sexual, financial, or other exploitation.		mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	<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. Management at facility level are then able to implement changes to practice, based on the evidence provided. A range of clinical indicator data are collected against each service level, and reported through to Ryman Christchurch (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.</p> <p>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 (myRyman). The system of data analysis and trend reporting is designed to inform staff at the facility level. Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the district health board which includes visits from specialists. The physiotherapist is available twice weekly from 8.30am to 4.00pm on Wednesday and from 8.30am to 12.00pm on Friday. There is a robust education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and annual competency assessments that monitor staff comprehension for a range of topics. Podiatry services visit every six weeks. The service has established links with the local community and encourages residents to remain independent.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<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 in the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Fifteen incident/accidents reviewed for September 2018 indicated that the next of kin are routinely contacted following an adverse event. Two-monthly resident and six-monthly family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed for residents who are unable to speak or understand</p>

		English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Jean Sandel is a Ryman Healthcare retirement village providing rest home, hospital and dementia level care for up to 132 residents. This includes 39 rest home level beds, 51 hospital dual-purpose beds, 22 dementia level beds and 20 serviced apartments certified as able to provide rest home level care. Occupancy at the time of the audit was 39 rest home residents in the ground floor rest home area. In the hospital area on level one, there are 12 rest home residents including two residents on respite care and 31 hospital level residents in the 51 dual-purpose beds including one resident on a long-term support chronic health condition (LTS-CHC) contract. There are 21 residents in the 22-bed dementia unit and one resident receiving rest home care in the serviced apartments. All other residents were on the age-related residential care (ARRC) contract.</p> <p>There is a documented service philosophy developed at head office that guides quality improvement and risk management in the service. Specific values have been determined for the facility. The village quality objectives and quality initiatives for 2018 have been set, with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2018 objectives.</p> <p>The village manager at Jean Sandel has been in the role since April 2018 and has a background in management within the banking industry. He is supported by a clinical manager who oversees clinical care and support for the village manager and an assistant manager who carries out administrative functions. The clinical manager has been in the position for 18 months and the assistant manager has been in the role for five and a half years. The wider Ryman management team included a regional operations manager who supports the management team.</p> <p>The village manager and clinical manager have maintained at least eight hours of professional development activities related to managing a village.</p>
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe	FA	The clinical manager is responsible during the temporary absence of the village manager, with support provided from the assistant manager and regional operations manager.

services to consumers.		
<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>Jean Sandel 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 review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Minutes are maintained. Audit summaries and quality improvement plans (QIP) are completed where a non-compliance is identified. QIPs reviewed for 2017 and 2018 have been closed out once resolved. 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. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and displayed in the staff room, showing trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes. The resident and relative satisfaction surveys were completed in February 2018 and July 2018 respectively with a high overall satisfaction rate. Quality improvement plans were implemented evidencing that suggestions and concerns were addressed.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (senior caregiver) was interviewed. She has completed external health and safety training level four. Health and safety meetings are conducted monthly. Risk management, hazard control and emergency policies and procedures are in place. There is an up-to-date hazard register which was last reviewed on 18 August 2018. 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 management and staff meetings. Ryman has achieved tertiary level ACC in the accredited employers programme, expiry 31 March 2019. Falls prevention strategies are in place that include; ongoing falls assessment, reviewing call bell response times, routine checks of all residents specific to each resident's needs (intentional rounding), encouraging resident participation in the activities programme and the use of sensor mats and night lights.</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>There is an incident reporting policy that includes definitions, and outlines responsibilities including 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. A review of fifteen incident/accidents forms identified that all are fully completed and include timely follow-up by a registered nurse (RN). Neurological observations were completed for four unwitnessed falls with a suspected injury to the head.</p> <p>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. The village manager and clinical manager were able to identify situations that would be reported to statutory authorities. One section 31 notification report was sighted for a stage four pressure injury in September 2018.</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 human resources policies including recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (one village manager, one clinical manager, four unit-coordinators, one RN, four caregivers, one activities coordinator and one kitchen assistant) included a signed contract, job description relevant to the staff members role, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff. A register of RN practising certificates is maintained. Practicing certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>There is an implemented annual education plan for 2018. Staff training records are maintained. 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. Staff are also required to complete a series of comprehension surveys each year. Five of thirteen RNs have completed their interRAI training. There are implemented competencies specific to RNs and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies. Education is specific at each monthly clinical meeting along with the journal club. Ten of thirteen caregivers who work in the dementia unit have completed their dementia qualification. The remaining three caregivers have been working in the unit for less than 18 months and are in the process of completing their dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>Ryman policy supports the requirements of skill mix, staffing ratios and rostering. There is a RN and first aid trained member of staff on every shift. Caregivers interviewed stated that management are supportive and approachable, and that there are sufficient staff on duty at all times. The village manager and clinical manager both work 40 hours per week. There are 20 serviced apartments certified to provide rest home</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>level of care. There was one rest home level resident living in the serviced apartments at the time of the audit. On the morning shift there is a unit coordinator (EN) and two caregivers and two caregivers on the afternoon shift. The caregivers in the rest home wing provide cover for the late afternoon and night shift. Interviews with residents and relatives confirmed that there are sufficient staff on duty.</p> <p>In the rest home unit there were 39 of 39 residents in total. On the morning shift: there is one unit-coordinator (RN), one RN and four caregivers (two long and two short shifts). On the afternoon shift, there is one RN, and three caregivers (two long and one short shifts), and on the night shift there are two caregivers with oversight from a hospital-based RN.</p> <p>In the hospital unit there were 43 of 51 residents in total (31 hospital and 12 rest home residents). On morning shift there is a unit coordinator (RN), two RNs and eight caregivers (four long and four short shifts). On the afternoon shift: there are two RNs and six caregivers (two long and four short shifts), and on the night shift there is one RN and three caregivers.</p> <p>In the dementia care unit there were 21 of 22 residents in total. On the morning shift: there is unit coordinator (RN), one RN and two caregivers. On afternoon shift, there is two caregivers (one long and two short shifts) and on night shift there are two caregivers with oversight from a hospital-based RN.</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. The service has an electronic system that includes all personal resident information. Access is all password protected and accessibility varies depending on your role. Personal surface tablets are situated in each resident room. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or RN including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry including information for village residents on the 48-hour complimentary care, short-term stays, rest home, hospital and dementia level of care services. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements were signed and dated. The respite care resident had signed a short-stay agreement.</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>	FA	<p>Policy 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. Communication with family occurs. Discharge summary and relevant information was sighted in the files of those residents discharged from hospital.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurses and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (rest home, hospital, serviced apartments and dementia care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. The RN signs the back of the blister pack when checked. An impress supply order is maintained for hospital level residents and expiry dates checked regularly. All medications were within the expiry dates. Eyedrops and ointments in all units were dated on opening. The medication fridges are checked weekly and temperatures sighted were within the acceptable range. There was one hospital resident and one rest home resident self-medicating 'as required' medications on the day of audit. Three monthly self-medication competencies had been completed by the RN and authorised by the GP. Monitoring forms had been completed. There were no standing orders. There were no vaccines stored on-site.</p> <p>Twenty-two medication charts on the electronic medication system were reviewed (eight hospital, eight rest home and six dementia care). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded on each chart. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. Medication administration observed, complied with policy.</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>There is a main chef and evening chef on daily, supported by cooks and kitchenhands. All food services staff have current food safety certificates. The food control plan has been submitted May 2018. Project 'delicious' is been implemented and the menus reviewed by a dietitian. The four-week rotating seasonal menu offers a variety of choices, including three main dishes for the midday and two choices for evening meal including a vegetarian option. Pureed/soft meals are provided. Gluten free meals are offered on the menu. Dietary needs are met through the project delicious menu options. The meals (in bain marie pots) are transported in hot boxes to the dining rooms, transferred into bain maries and served directly from these. Special equipment such as lipped plates are available. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen. There are snacks available at all times in the</p>

		<p>dementia unit.</p> <p>Chiller, freezer and end cooked temperatures, are taken and recorded twice daily. A cleaning schedule is maintained. Chemicals are stored safely.</p> <p>Residents and family members interviewed were satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings and surveys.</p>
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Eleven resident files reviewed, indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the VCare system within 24-48 hours of admission for all residents entering the service including the respite short-stay resident. There were no residents admitted under the 48-hour complimentary service for village residents. InterRAI assessments had been completed for all long-term residents under the ARCC within 21 days of admission. Applicable VCare assessments are completed and reviewed at least six monthly or when there is a change to residents' health/risk. The outcome of all assessments is reflected in the myRyman care plan. Behaviour assessments had been completed for the files of three dementia care residents with the outcomes including use of activities documented in the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	MyRyman care plans reviewed, evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred including medical conditions, activities of daily living and supports, activities, cultural and spiritual supports. Interventions documented support needs, resident goals and provided detail to guide care. Behaviour management plans were in the myRyman care plan for the three dementia care resident files reviewed. Strategies for de-escalation including activities, were documented in the myRyman care plan. Residents and relatives interviewed, stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist

		<p>care professionals including the physiotherapist, hospice nurse, dietitian, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.</p>
<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>When a resident's condition changes, the registered nurse initiates a GP or nurse specialist consultation. Registered nurses interviewed, stated that they notify family members about any changes in their relative's health status. Family members interviewed, confirmed they are notified of any changes to health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. MyRyman care plans are updated when there are changes to health, risk, infections or monitoring requirements.</p> <p>Care staff interviewed, stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are documented electronically, and wound monitoring occurs as planned in the sample of wounds reviewed (seven hospital, three rest home and one dementia care). There were two pressure injuries (one rest home resident with facility acquired stage two and one hospital resident with a stage four on admission). There has been input from the GP and wound care nurse specialist in the management of the pressure injuries. Photos of wounds demonstrate healing progress. The wound care champion is the rest home coordinator. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position and pressure area cares electronically.</p> <p>Electronic monitoring forms are in use as applicable, such as weight, food and fluid, vital signs, blood sugar levels, pain, bowel monitoring, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</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>A team of activity coordinators include three qualified diversional therapists (DT). Each unit has a DT who is supported by activity coordinators and lounge carers to implement the Engage activities programme that reflects the physical and cognitive abilities of the resident groups. The programme is Monday to Friday in the rest home and seven days a week in the hospital and dementia care units. There are volunteers for each unit who assist with the programme and one-on-one activities.</p> <p>There is a weekly programme for each unit in large print on noticeboards and residents have a copy in their rooms. The programmes include set Engage activities in which residents can choose to participate, including (but not limited to); triple A exercises, board games, mind benders, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home resident in a serviced apartment can choose to attend the serviced apartment or rest home activity programme. One-on-one time is spent with residents who prefer to stay in their room or are unable to actively participate in group activities. The programme in</p>

		<p>the dementia care unit is flexible to meet the residents needs and abilities. Caregivers include activities as part of their role. There are plenty of resources available to staff.</p> <p>The service hires a mobility van for hospital resident outings and there are two vans for rest home and dementia care resident outings. The van driver has a first aid certificate. Residents attend events in the community such as garden festivals, festival of the lights, library, parks, cafés and movies. Community visitors include entertainers, pet therapy, kapa haka groups, pre-school children, primary school children and church groups. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision. The men's club (rest home, hospital and dementia care residents) enjoy outings and activities of interest. Special events and theme days are celebrated. Recently, residents created and entered a wearable arts outfit in the Taranaki Fashion Arts award and were one of the finalists.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan (incorporated into the myRyman care plan) is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Five long-term resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. One resident was respite care and did not require an evaluation of care. Five residents had not been at the service long enough for an evaluation. The multidisciplinary review involves the RN, CG, activity coordinator and resident/family are invited to attend. Activities plans are evaluated at the same time as the care plan. There are three monthly reviews by the GP, or earlier for residents with more complex needs. Family members interviewed confirmed that they are informed of any changes to the care plan.
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	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound nurse specialist, geriatrician, mental health services for older people, hospice, speech language therapist and dietitian. Discussion with the registered nurses identified that the service has access to a wide range of support through the GP, specialists and allied health services as required.

facilitated, or provided to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. There is a chemical mixing dispenser system available in the cleaners' cupboard. All chemical bottles have manufacturer labels.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building holds a current warrant of fitness which expires 24 January 2019. There is a full-time maintenance manager who is on the health and safety committee and holds a site safety certificate. There is a separate gardening team. A maintenance register at the main reception is available for staff/residents to record maintenance/repairs required. There is a planned maintenance schedule that had been completed on a monthly basis and includes environmental and residential equipment checks. Contractors are available when required. Electrical equipment has been tested and tagged. Clinical equipment including the hoists and scales are checked annually. Hot water temperatures in resident areas are taken three monthly as part of the environmental audit and were within the acceptable range.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, gardens and courtyards are well maintained and safely accessible. All outdoor areas have seating and shade.</p> <p>The dementia unit is on the second floor with an outdoor safe deck area with raised garden beds. An indoor/outdoor walking pathway is accessible for residents.</p> <p>Caregivers interviewed, stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with	FA	All rooms have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all toilet doors including communal toilets located near the communal areas.

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	<p>There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalised their bedrooms as viewed on the days of audit.</p>
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	<p>The rest home and hospital have separate dining rooms and lounges where activities take place. There is a library and hair salon available for all residents. There are seating alcoves within the rest home and hospital units and a smaller lounge where quieter activities can take place.</p> <p>The dementia unit has an open plan dining room and lounge area with a separate family/quiet room. The seating is arranged to allow for small group/individual activities.</p>
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	CI	<p>All laundry and personal clothing is done on-site. The laundry is divided into a 'dirty and clean' area with an entry and exit door. There is a laundry and cleaning manual and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The chemical provider monitors the effectiveness of the laundry and cleaning processes. Staff have attended chemical safety training and annual infection control education.</p> <p>The cleaner's equipment was attended at all times or locked away when not in use. The cleaning staff use a caddy for chemicals when they enter resident rooms for cleaning. All chemicals on the cleaner's trolley were labelled.</p> <p>In May 2017 the facility commenced a laundry project. They installed a labelling machine and the 'purple bag' for residents clothing in order to reduce the amount of unnamed/missing clothes items. This project has been evaluated and has been successful.</p>

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>There is an emergency and disaster management plan in place to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme and staff annual comprehension competency. There is a first aid trained staff member on every shift and accompanying residents on outings. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 8 May 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked annually.</p> <p>Sufficient water is stored for emergency use and alternative heating and cooking facilities (two BBQs, gas hobs in the kitchen and two portable gas cookers) are available. There is an NZ fire service approved fire evacuation plan dated 5 February 2010. There are two generators to cover the care centre and the village if there is a power failure. Smoke alarms, sprinkler system and exit signs are in place. The facility is secured at night. There are call bells in all resident rooms, toilet/shower areas and communal areas. Security systems are being implemented to ensure residents are safe. Staff confirmed that they conduct security checks at night. Visitors and contractors sign in at reception when visiting.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. There is underfloor heating throughout the building. Residents and relatives interviewed stated the environmental temperature was comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is the hospital unit coordinator/registered nurse and has been in the role two months. She is supported and mentored by the previous infection control officer and clinical manager who collates the monthly infection control data. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets two monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within 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) meet two monthly. The infection control officer has completed an induction to the role and is yet to attend specific education relating to the role. The clinical manager attended the Ryman annual skype conference for infection control officers which included an external speaker in March 2018. There are daily RN 'huddles' that include discussions around infection control/infections. Monthly reports are provided to the committee, management and facility meetings including trends and analysis of infections.</p> <p>The infection and prevention officer has access to an external infection prevention and control specialist including DHB, infection control specialist, microbiologist, 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 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	<p>There are comprehensive infection prevention and control policies that are 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 referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate. Policies are available to all staff through the Ryman library on-line.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>

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	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed on the VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and clinical manager completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and meeting minutes/graphs are displayed. Benchmarking occurs within the organisation.</p> <p>There have been no outbreaks since the last audit.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>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 a restraint and one resident using an enabler (bed rail). The resident file for the resident using enablers reflects a restraint/enabler assessment and voluntary consent by the resident. Staff training has been provided around restraint minimisation and enablers, last occurring in October 2018.</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
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. One QIP reviewed, reflected a reduction in resident's incidents of challenging behaviour in the dementia unit. In September 2017, the service identified an improvement was required around a high number of incidents of challenging behaviour in the dementia unit.	The achievement of the rating that service provides an environment that encourages managing and analysing quality data beyond the expected full attainment. The service has conducted a number of QIPs where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. In September 2017 the service identified an improvement was required around a high number of incidents of challenging behaviour in the dementia unit. A QIP was developed which included strategies and actions to reduce the number of incidents of challenging behaviour in the dementia unit. The plan has been reviewed monthly and discussed at clinical staff meetings. The service has been successful in reducing and better managing incidents of challenging behaviour within the dementia unit. A review of the data evidenced a reduction from 9.2/1000 bed nights of incidents of resident challenging behaviours in September 2017 to 1.5/1000 bed nights in September 2018. There were zero incidents for the months of March, May and August 2018.

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>A quality improvement plan (QIP) is implemented where opportunities for improvements are identified. QIPs are regularly reviewed and evaluated. One QIP reviewed, reflected a significant reduction in residents falls at the rest home level of care.</p>	<p>Data collated is used to identify any areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Corrective action plans that have been implemented and evaluated around the reported number of hospital level residents' falls reflected significant improvements. Falls in the hospital wings were identified in September 2017 as an area that required improvement (11/1000 bed nights). A plan was developed, which included identifying residents at higher risk of falling or needing closer observation and highlighting those residents at risk through a colour coding (traffic light) system, review of call bell response times, providing falls prevention training for staff, ensuring adequate supervision of residents, and encouraging resident participation in the activities programme.</p> <p>Other initiatives included physiotherapy assessments for all residents, routine checks of all residents' specific to each resident's needs (intentional rounding), the use of sensor mats, night lights and increased staff awareness of residents who are at risk of falling. Caregivers and RNs interviewed were knowledgeable in regard 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 benchmarked data for the 12-month period ending in August 2018, evidenced an average (rest home level) falls rate that is consistently below the Ryman benchmarked target (7.83/1000 bed nights).</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>Laundry processes reflect an area of continuous improvement and increased resident satisfaction in the laundry service.</p>	<p>The laundry project initiated in May 2017, aimed to reduce un-named clothes and reduce complaints around the laundry service. Each resident was provided with individually labelled purple laundry bags for their personal use. These labelled 'purple bags' were seen in residents' ensuites. The organisation purchased a labelling machine and the laundry personally label all residents' personal items on admission and as required. Staff received training on the new machine and the laundry processes. Relatives were informed of the labelling process and encouraged to bring new clothing to the laundry for labelling. Laundry staff were reminded of the importance of delivering clothing to the right residents and taking any unlabelled clothing to the units to find the owners. On the day of audit, the laundry staff were knowledgeable about the labelling process and confirmed the unlabelled clothing had greatly reduced. There was a small basket of unlabelled clothing seen on the day of audit.</p> <p>Residents and relatives were informed of the laundry procedures. Laundry audits have</p>

		evidenced an improvement in laundry procedures. The service has been successful in reducing the amount of un-named/missing clothing. The February 2018 resident satisfaction survey demonstrated an increase from 3.85 in 2017 to 4.14 in 2018.
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End of the report.