Ryman Healthcare Limited - Margaret Stoddart Retirement Village

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Ryman Healthcare Limited
Premises audited:	Margaret Stoddart Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 October 2018 End date: 24 October 2018

Proposed changes to current services (if any): Two serviced apartments have been converted to residents' rooms, therefore increasing the number of resident rooms from 41 to 43. The number of serviced apartments certified for rest home level of care have been reduced from 25 to 23.

Total beds occupied across all premises included in the audit on the first day of the audit: 48

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

Margaret Stoddart is part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home level of care for up to 43 in the care centre and rest home level of care for up to 23 residents in serviced apartments. On the day of audit there were 41 residents in the care centre and 7 rest home residents in the serviced apartments.

This unannounced surveillance audit was conducted against a sub-set of 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 the general practitioner.

The service is managed by a village manager who has been with Ryman for four years and in the current role for 14 months. She is supported by an experienced clinical manager/registered nurse. The residents and relatives interviewed spoke positively about the care and support provided.

The service continues to be fully attained across the standards audited.

The service is commended for maintaining a continuous improvement rating around food service and activities programme.

Consumer rights

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

Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Relative meetings for each unit are held regularly. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Quality improvements plans are developed and evaluated where opportunities for improvements are identified. The quality and 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. An orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments. Registered nursing cover is provided seven days a week. Residents and families report 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.		All standards applicable to this service fully attained with some standards exceeded.

Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. MyRyman electronic plans demonstrate service integration, are individualised and evaluated six-monthly. The resident/family/whānau interviewed confirmed they are involved in the care plan process and review. The general practitioner reviews the resident three monthly.

The activity officers coordinate and implement the Engage activities programme. The programme meets the recreational needs of the residents and is varied and interesting, and involves the families and community.

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. There are three-monthly GP medication reviews.

Meals are prepared on-site. The menu is designed by a dietitian at organisational level. The food control plan has been verified. The menu plan provides meal options. Residents interviewed commented positively about 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.		Standards applicable to this service fully attained.

The building has a current warrant of fitness.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraints or enablers at the time of the audit. Staff receive training around restraint minimisation.

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 officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. 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	14	0	0	0	0	0
Criteria	2	39	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 1.1.13: 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 residents and family members confirmed their understanding of the complaints process. The village manager has overall responsibility for ensuring all complaints are fully documented and investigated. The clinical manager and regional operations manager are involved in clinical complaints. The facility has an up-to-date complaint register. Concerns and complaints are discussed at relevant meetings. Ten complaints have been received since the last audit (five in 2016, one in 2017 and four in 2018 year to date). All complaints reviewed have been managed in a timely manner and are documented as resolved.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Five residents interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Ten incident forms reviewed for October 2018 evidenced the family had been informed of an accident/incident. Four relatives interviewed stated that they are informed when their family members health status changes. Two monthly resident and six monthly relative meetings provide a forum for residents and families to discuss any issues or concerns. Non-subsidised residents are advised in writing of their eligibility and the process to become a

conducive to effective communication.		subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Margaret Stoddart Retirement Village is a Ryman Healthcare facility, situated in Christchurch. The service currently provides care for up to 66 residents at rest home level care including 23 serviced apartments that are certified to provide rest home level of care. There were 48 residents in the facility on the day of audit including seven rest home residents in serviced apartments. There were four residents on respite care including one respite resident in the serviced apartments. All other residents were on the age related residential care contract (ARRC) Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. The organisation-wide objectives are translated at each Ryman service. Facilities are required to set quality objectives annually. Quality objectives for the 2017 year have been reviewed and 2018 objectives are in place. The village manager is non-clinical who has been in this role since August 2017 and has worked at Ryman for over five years. The village manager is supported by a full-time clinical manager. The clinical manager has been in the role for two years and has worked for Ryman for four years. Management are supported by a regional operations manager and operations support/project leader (who was present at the time of the audit). The village manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Margaret Stoddart service has an established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings (teamRyman, full facility, clinical, and infection control/health and safety meetings) and reported to the organisation's management team. Discussions with the management team (village manager and clinical manager) and staff, and review of 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. The annual resident and relative satisfaction surveys were completed in February 2018 and July 2018 respectively. Quality improvement plans have been implemented, evidencing that suggestions and concerns were addressed. Results and the areas for improvement have been fed back to staff and participants through full facility resident and relative meetings. 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. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are developed for audit outcomes less than 90%. Re-audits are completed as required. The facility has processes in

		place to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being signed off when completed. Health and safety policies are implemented and monitored. The health and safety officer (village manager) was interviewed. She has completed external health and safety level four training. Health and safety meetings are conducted bi-monthly. Risk management, hazard control and emergency policies and procedures are in place. 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. Falls prevention strategies are in place that include; reviewing call bell response times and the roster to ensure adequate supervision of residents, routine checks of all residents specific to each resident's needs (intentional rounding), encouraging resident participation in the triple A activities programme and the use of sensor mats.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	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 10 incident/accident forms identified they all are fully completed, including follow-up by a registered nurse (RN) and relative notification. Post falls assessments included neurological observations for two unwitnessed falls with potential head injury reviewed. The clinical manager is involved in the adverse event process, with links to the relevant meetings. This provides the opportunity to review any incidents as they occur. The village manager was able to identify situations that would be reported to statutory authorities. There has been one section 31 notification made since the last audit, for a sapovirus outbreak in May 2017 which was also reported to the public health authorities.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good	FA	There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files reviewed, including one clinical manager, three caregivers and one activities coordinator, provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RN and enrolled nurse (EN) practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration. An orientation/induction programme provides new staff with relevant information for safe work practice. There is an annual education plan in place for 2018. Additional toolbox sessions are provided. Communication

employment practice and meet the requirements of legislation.		folders in each unit contain education content for staff to read and sign if they have not attended the education session. Staff training records are maintained. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. Registered nurses are supported to maintain their professional competency. There are currently three RNs working at Margaret Stoddart and two RNs are interRAI trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. This defines staffing ratios to residents and rosters are in place. The village manager and clinical manager work full time and are on call 24/7. Interviews with five caregivers stated the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are overall sufficient staff to meet resident needs. There is a pool of casual staff to cover unplanned absences. Staffing at Margaret Stoddart is as follows; there are 43 beds in the care centre and at the time of the audit there were 41 residents. There is a clinical manager or RN on duty with four caregivers (two long and two short shifts) on the morning shift, three caregivers (two long and one short shift) on the afternoon shift and two caregivers on night shift. In the serviced apartments, there are 23 rest home certified beds and there were seven rest home residents on the day of the audit. There is a serviced apartment unit coordinator/enrolled nurse (EN) or senior caregiver with one caregiver on the morning and afternoon shifts. The caregivers in the care centre cover the serviced apartments at night.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. The RNs and senior care assistants who administer medications have been assessed for medication competency. Education around safe medication administration has been provided. Medication reconciliation of monthly blister packs is completed by an RN against the electronic medication chart and evidenced by a signature on the back of the blister pack. All medications sighted were within the expiry dates. All medications are stored safely in the one medication room. Medication fridges are monitored daily with recordings within acceptable ranges. All eye drops and creams in medication trolleys (rest home and serviced apartments) were dated on opening. There was one resident self-medicating and competencies were current. Ten medication charts were reviewed on the electronic medication system. All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that medications are administered as prescribed and the indication for use is documented for ‘as required’ medications. The effectiveness of ‘as required’ medications is entered into the electronic medication system.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	CI	All food and baking is prepared and cooked on-site. The qualified head chef is supported by one other chef, a cook and a team of morning and afternoon kitchen assistants. Staff have been trained in food safety and chemical safety. The food control plan was verified 19 June 2019. "Project delicious" was introduced in January 2017. The menu provides two choices for the evening meal with the main meal at midday. Diabetic desserts and gluten free diets are accommodated. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Meals are served from a bain marie to the residents in the dining room. Meals plated and delivered to rooms are kept hot with insulated lids (top and bottom). The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Alternative foods are offered for dislikes. Freezer, chiller, end cooked and cooling temperatures are taken and recorded. The chilled goods temperature is checked on delivery. All perishable foods sighted in the chiller were date labelled. Dry goods in the pantry were within the expiry dates. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents can provide feedback on the meals through resident meetings, survey, direct contact with the food services staff and comments book. Residents and relatives interviewed spoke positively about the choices and meals provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP or nurse specialist consultation. The clinical manager 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. Care plans have been updated as residents' needs changed. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. There were wound assessment, wound management and evaluation forms in place for 10 residents. Wound monitoring occurs as planned, in the sample of wounds reviewed. The GP is notified of wounds for review as required. Non-healing and complex wounds demonstrate wound nurse specialist involvement in wound care management. There is one stage one facility acquired pressure injury of the sacrum. The daily task list includes use of roho cushion, re-positioning and adequate fluids which is signed out as completed each shift. Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	There is a qualified diversional therapist for the rest home and an activity coordinator for the serviced apartments. The DT is employed for 35 hours a week Monday to Friday. She is supported by a lifestyle manager at head office and attends education and recreational workshops with guest speakers. The Engage programme has set activities with the flexibility to add activities that are meaningful and relevant for the residents. Rest home residents in the serviced apartment may choose to attend either the serviced apartment or rest home programme. Daily contact is made with residents who choose not to be involved in the activity programme. The DT has initiated small group or one-on-one activities for residents with memory loss such as colouring, walks, puzzles and art. Resources are available. There are a number of volunteers including village residents, preschool children and high school students involved in the Engage programme. There are regular outings/drives offered for all residents, weekly entertainment and involvement in community events. Residents are encouraged to maintain links with the community including inter-home sports day and bowls. The men's club continues to enjoy activities and outings of interest. A painting club and books of residents' lives have been developed since the last audit. The service has continued to maintain a continuous rating around activities. Activity assessments are completed for residents on admission. The activity plans 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. Relative and residents interviewed expressed satisfaction with the Engage programme and other activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files reviewed identified that care plans had been evaluated by registered nurses at least six-monthly. Written evaluations for long-term residents describe the resident's progress against the resident's identified goals and any changes are updated on the myRyman care plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review. Family members and the resident are invited to the six-monthly review. Care staff, diversional therapist, GP and allied health professionals involved with the residents provide input into the care plan review. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	FA	The building has a current warrant of fitness that expires 2 July 2019. There is a reactive and planned maintenance programme in place. Two serviced apartments have been converted to premium large resident rooms with ensuites. The number of resident rooms have increased from 41 to 43 and the number of serviced apartments have been reduced from 25 to 23.

accessible physical environment and facilities that are fit for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy 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 for all infections and are kept as part of the resident electronic files. Infections are included on an electronic register and the infection control coordinator (clinical manager) completes a monthly report. Monthly data is reported to the full facility and clinical meetings. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. A confirmed sapovirus outbreak occurred in July 2017. Notifications to the public health and HealthCERT were sighted. Outbreak management documentation was viewed including case log, outbreak management report and staff debrief minutes.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint policy in place that states the organisations philosophy to restraint minimisation. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with any restraints or enablers at Margaret Stoddart. Staff are trained in restraint minimisation, last occurring in December 2017.

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 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	Ryman has introduced a number of systems to ensure residents nutritional needs are met and the dining experience improved. This has been achieved with the introduction of “project delicious” in February 2018.	The head chef was involved in the development of the menu plan in consultation with the dietitian at head office. Menu choices were trialled and adjusted with input from residents. The four-week rotating seasonal menu offers a variety of choices including two choices for evening meal, including a vegetarian option, a chef’s choice and residents’ choice each week. Gluten free meals and vegetarian options are on the menu. Dietary needs are met through the “project delicious” menu options. The service has liaised with food suppliers to improve quality of suppliers including access to specialised pure foods for pureed options. The dining room has been set up to reflect an ambience of relaxed dining as observed during meal times. Feedback from residents regarding the menu was to clarify what the food items were, and this prompted changes to the wording around meals/food items. Evaluation of the “project delicious” menu and dining experience has been measured by; 1) Feedback from residents at the resident meetings. There have been very positive comments recorded in the minutes sighted since the introduction of project delicious. 2) Ongoing education for staff around food services, dining room etiquette, nutrition and hydration. 3) Positive feedback recorded in the comments book in the dining room. 4) Interviews with five residents and four relatives all stated the meals (choice, quality and presentation) were very good. The annual survey post “project delicious” implementation is due February 2019. The service has been successful in providing excellence in food services from the documented evidence to date.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Ryman Margaret Stoddart introduced new activities in January 2017 that residents had not experienced before with an aim personalise activities and get to know residents better. The service has achieved this through the painting club participants and introducing individual memory books.	1) A painting club was formed with residents with a particular interest in painting, including an artist who encouraged residents to produce original paintings for an exhibition. The paintings were displayed at an exhibition in May 2018 at the Christchurch gallery. Residents were taken to the gallery to see their works displayed. 2) A village choir was formed that included all care centre and village residents with a passion for singing and involvement in opera and producing concerts for residents. The choir put on a concert for other residents every two months and invite a guest musician to join them in the concert. 3) In May 2017 a book was published “Lives Well Lived” showing the early lives of residents. The writing process and publishing of the book brought residents, relatives and staff together as they worked through the process. The book (viewed) had written stories of resident’s lives and well-illustrated with colour and black and white photos. 4) “making memories” is an individual booklet which is completed by the resident and their family so that memories are remembered and read. Time is scheduled into the activity calendar to assist the resident with filling in the booklet. This personalised activity strengthened staff connections with residents and their families. Direct feedback from resident and relative interviews, meeting minutes sighted, and the relatives survey result evidenced an increase in satisfaction in the Engage programme. Margaret Stoddart rate second in the group for the 2018 relative survey results for the Engage programme.

End of the report.