

Ryman Napier Limited - Princess Alexandra

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 Napier Limited
Premises audited:	Princess Alexandra Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 January 2015 End date: 30 January 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	104

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Princess Alexandra Retirement Village is a Ryman Healthcare facility, situated in Hawkes Bay. The facility provides rest home, hospital level and specialist dementia care. On the day of audit there were 44 rest home residents (including eight in a serviced apartment), 37 hospital residents and 23 residents in the dementia unit. The village manager is supported by a clinical manager (registered nurse) and an assistant village manager. There are systems in place that provide appropriate care for residents. Implementation was being supported through the Ryman Accreditation Programme. An induction and in-service training programme was being implemented that provided staff with appropriate knowledge and skills to deliver care.

The service had addressed the two shortfalls from the previous certification audit around completion of risk assessment tools and medication documentation and timely administration of medication.

This surveillance audit also identified improvements required around meeting minutes, closure and/or monitoring of quality improvement plans, staff education, staffing, and timeliness of service delivery, care plan interventions and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is an open disclosure policy. Interviews with residents and relatives confirmed family are kept informed of their family members current health status. A complaints process was being appropriately implemented.

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.		Some standards applicable to this service partially attained and of low risk.
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Princess Alexandra is implementing the Ryman Accreditation Programme that provides the framework for quality and risk management. Key components of the quality management system link to a number of meetings including staff meetings. The clinical meeting minutes did not consistently record resident incidents and trends and this is a required improvement. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Princess Alexandra monitors clinical indicator data for the three services being provided (hospital, rest home and dementia). Quality improvement plans have been developed to improve service delivery, however a number had not been evaluated and closed out and this is a required improvement. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care, however attendance did not meet requirements. In addition there are a small number of inductions overdue and these are areas for improvement. The organisational staffing policy aligns with

contractual requirements. The service has reportedly had a high turnover of staff and continues to work towards stabilising the workforce, and this is an area for improvement.

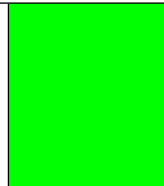
Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Initial assessments and risk assessment tools are completed on admission by the registered nurse. The previous finding around the use of nutritional assessments has been addressed. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans demonstrated service integration. This audit identified an improvement required around documentation of interventions to reflect the resident's current health and mobility status. The residents and family interviewed confirmed they are involved in the care planning and review process. Short term care plans were in use for changes in health status. The general practitioner reviews the residents at least three monthly. There is an improvement required around timely medical and clinical re-assessments. The diversional therapist and activity coordinators provide separate activity programmes for rest home, hospital and special care residents. The Engage programme ensures the individual abilities and recreational needs of the consumer groups are met. Staffs responsible for medication administration have completed annual competencies and education. There were three monthly GP medication reviews. The previous finding around medication documentation and timely administration of medication has been addressed. This audit identified an improvement required around medication charts and medication administration. Meals were prepared on site. The menu was approved by a dietitian at organisational level. Individual and special dietary needs were catered for. Alternative options were provided. There were nutritious snacks available in the special care unit.

Safe and appropriate environment

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

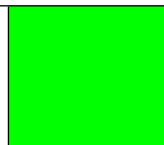


Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

There are comprehensive policies and procedures that meet the restraint standards. There is a restraint co-ordinator with delegated responsibilities for monitoring enabler and restraint use. The service currently has two hospital residents with enablers. Voluntary consent and assessments have been completed. There are four residents with restraints with the required documentation completed as per policy.

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 and complexity of the service. The infection control officer (registered nurse) uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. In-service education is included as part of the annual training programme. 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	0	11	0	3	3	0	0
Criteria	0	35	0	4	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy is being implemented at Princess Alexandra. The village manager has overall responsibility for ensuring all complaints (verbal or written) were fully documented and investigated. A feedback form was completed for each complaint recorded on the complaint register. The complaints register included relevant information regarding the complaint. Documentation including follow up letters and resolution were available. Verbal complaints were included and actions and response documented. The numbers of complaints received each month were reported to staff via the various meetings – e.g. full facility, clinical meeting. Discussion with five residents and three relatives confirmed they were provided with information on the complaints process. A complaints procedure is provided to residents within the information pack at entry. There was written information on the service philosophy and practices particular to the dementia unit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Princess Alexandra is recording resident incidents on the prescribed form which includes a section to record family notification. Incident forms reviewed indicated this required is met. Data is then entered into Ryman VCare system for</p>

effective communication.		benchmarking. Three family members (two hospital, one dementia) interviewed confirmed they were notified following a change of health status of their family member. There is an interpreter policy and contact details of interpreters were available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Princess Alexandra is a Ryman Healthcare retirement village. The service provides rest home, hospital and dementia level care for up to 108 residents in the care centre. Thirty serviced apartments have previously been certified as suitable to provide rest home level care. There were 104 residents in the facility on the day of audit including 44 rest home (of which eight were in a serviced apartment), 37 hospital level residents and 23 in the dementia unit. There is a contracted physiotherapist, and a contracted medical centre providing general practitioner services.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. The philosophy of the service includes providing safe and therapeutic care for residents with dementia. Quality objectives and quality initiatives from an organisational perspective are set annually and each facility then develops their own specific objectives. Service specific objectives are reviewed as prescribed in the RAP. The village manager reported a focus on developing the team culture will be a goal for the 2015 year.</p> <p>The village manager at Princess Alexandra has been in the role for just over one year and is a registered nurse. She was supported by an assistant manager (non clinical) who carries out administrative functions and a clinical manager (registered nurse) who oversees clinical care. The assistant manager and clinical manager have both been in their roles for less than a year. The clinical manager has resigned from her position and was working a period of notice at the time of audit. The management team is supported by the wider Ryman management team including a regional manager. The village manager and clinical manager have maintained at least eight hours of professional development activities related to managing a village.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	PA Low	Princess Alexandra was implementing the Ryman Accreditation Programme (RAP) which links key components of the quality management system to village operations. The RAP Committee meet monthly at Princess Alexandra. Outcomes from the RAP Committee are then reported across the various meetings including the full facility, clinical meetings. The clinical meeting minutes did not consistently record resident incidents and resulting trends. Information recorded in other facility meeting minutes

<p>principles.</p>	<p>strengthened during the 2014 year to include discussion about the key components of the quality programme. Resident (and relative) meetings occur, however there are occasions where issues raised were not reported as followed up at the subsequent meeting.</p> <p>Policy review is coordinated by Ryman head office. Policy documents have been developed in line with current best and/or evidenced based practice. Facilities have a master copy of all policies and procedures and the related clinical forms. Facility staff are informed of changes/updates to policy at the various staff meetings. In addition, a number of core clinical practices have staff comprehension surveys that staff are required to be completed to maintain competence. The surveys have been completed by the various staff groups. There are also education packages being implemented that are based on Ryman policies.</p> <p>The RAP prescribes the annual internal audit schedule that was being implemented at Princess Alexandra. Audit summaries and QIPs are completed where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee e.g. RAP, health and safety.</p> <p>Monthly clinical indicator data is collated across the rest home (including rest home residents in the serviced apartments), dementia and hospital services. There is evidence of trending of clinical data, and development of QIPs when volumes exceed targets – eg. weight loss, skin tears. Falls prevention strategies are in place that include, hi/lo beds, ongoing falls assessment by the physiotherapist, and sensor mats. QIP's have also been developed to address issues raised through the 2014 resident/relative survey and complaints. A small number of QIP's reviewed had no progress reported, evaluation and/or sign out.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Facilities are required to set quality objectives annually. Princess Alexandra had four defined quality objectives for the 2014 year. The QIP process is used to plan and evaluate progress towards village specific objectives. Princess Alexandra was in the process of confirming 2015 objectives at the time of audit with the village manager reporting a focus on developing the team culture as a goal for the coming year.</p> <p>There is a health and safety, and risk management programme being implemented at Princess Alexandra. The combined health and safety and infection control committee met bimonthly and included discussion of incidents/accidents and infections. There was a safety representative and a current hazard register.</p>
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<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>	<p>FA</p>	<p>Princess Alexandra collected incident and accident data on the prescribed form which was then entered into the benchmarking programme. Incidents were reviewed and all had been completed with appropriate clinical follow up. Monthly analysis of incidents by type was undertaken by the service and reported to the various staff meetings. QIPs were created when the number of incidents exceeded the benchmark (link 1.2.3.8). Senior management were aware of the requirement to notify relevant authorities in relation to essential notifications.</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>	<p>PA Low</p>	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. There are also job descriptions for the infection control coordinator, restraint coordinator, in-service educator, health and safety officer, fire officer. Appropriate recruitment documentation was seen in the 10 staff files reviewed (diversional therapist, chef, four care assistants, three registered nurses and one enrolled nurse). A register of practising certificates is maintained. Performance appraisals are current in files reviewed. Interview with the management team (clinical manager and assistant village manager) inform the service has experienced a relatively high staff turnover over the past year. Recruitment is underway (also refer 1.2.8.1).</p> <p>There is an annual training plan aligned with the RAP that was being implemented. Attendance at some training linked to the required standards was well under 50%. There was an enrolled nurse who oversees staff participation in the ACE programme which was a requirement for care assistants. Ryman ensures registered nurses (RN) are supported to maintain their professional competency. There is an RN journal club that meets two monthly at Princess Alexandra. Ryman has a 'Duty Leadership' training initiative that all registered and enrolled nurses and senior leaders complete.</p> <p>There is an induction programme being implemented with completion being monitored and reported monthly to head office as part of the RAP programme. Interview with staff informed the induction programme meets the requirements of the service. Induction for new care staff was seen to be current (and/or in progress), however there were outstanding inductions for key roles. While all but one care assistant working in the dementia unit had completed the required dementia standards, unexpected absence was covered by bureau staff and the service was unable to confirm that this group of staff are suitably qualified to work in the unit.</p> <p>The clinical structure in the facility includes a clinical manager, coordinators in each service area (registered nurses) and a team of registered nurses and care staff. The</p>

		serviced apartments (where there were nine rest home level residents) also had a coordinator (enrolled nurse).
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA Low	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The care centre is overseen by a fulltime clinical manager, and registered nurse coordinators in the rest home, hospital and dementia unit. There was an enrolled nurse coordinator working in the serviced apartments (where there were eight rest home residents at the time of audit). There was at least one registered nurse and first aid trained member of staff on every shift.</p> <p>Interview with the management team (clinical manager and assistant village manager) inform the service has experienced a relatively high staff turnover (care assistants) over the past year and at the time of audit recruitment continues. Use of bureau is evident. The clinical manager informed she has resigned her position (she is relocating) and she was working out a period of notice at the time of audit. Recruitment to the position is underway. A strategy to cover a period of transition was reported to be in place.</p> <p>Review of the rosters suggests sufficient staff numbers to meet resident numbers, however review of allocation and skill mix based on acuity is required.</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>	PA Moderate	<p>All medication is managed appropriately in line with required guidelines and legislation. RNs, enrolled nurses and senior care givers responsible for the administering of medication complete annual medication competencies and attend annual medication education. Medications are checked on delivery against the medication chart. There was one self-medicating resident in the hospital unit. The previous finding around medication administration documentation has been addressed. This audit identified an improvement around medication charts and medication administration.</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>The service employs a food services manager Monday to Friday and a weekend chef. They are supported by a second cook and kitchen assistant each day. There is a four weekly seasonal menu that has been reviewed by a dietitian at organisational level. The kitchen staff receive a resident dietary profile for all new admissions and are notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Staff were observed sitting with the residents when assisting them with meals.</p>

		<p>The service is well equipped. The freezer and fridge temperatures are checked daily. There are 24/7 service contractors. Hot food (end cooked) temperatures are recorded daily. All foods are date labelled. There were nutritious snacks available in the special care unit. A cleaning schedule is maintained. Chemicals are stored safely. Feedback on the service is received from resident and staff meetings, surveys and audits.</p> <p>D19.2: Staff have been trained in safe food handling and chemical safety.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Nutritional screening tools were completed on admission in the resident files sampled. Mini nutritional assessments were reviewed six monthly or earlier as identified in two hospital and one special care unit files sampled for residents with weight loss. The previous audit finding has been addressed.</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>	PA Moderate	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Faxes to the GPs for residents change in health status and responses were sighted in the resident's files. Not all care plans reflect the residents current health status</p> <p>D18.3 and 4 Dressing supplies were available and treatment rooms were adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency were in place for chronic wounds (ulcers). There was evidence of GP, wound nurse and vascular clinic involvement in chronic wound management. There were no pressure areas.</p> <p>Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. RNs interviewed described access to nursing specialists as required.</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</p>	FA	<p>A team of one diversional therapist (special care unit), three activity coordinators (rest home, hospital and serviced apartments) and one activity assistant implement a separate Engage activity programme for their areas. The Engage programme is delivered Monday to Saturday in the special care and hospital units. The Engage</p>

<p>service.</p>		<p>programme includes set activities as per the Ryman policy and the activity team provide additional activities that meet the individual and recreational needs abilities of the consumer group. The Triple A exercise programme which is applicable to the cognitive and physical abilities of the resident group. The activity assistant spends one on one time with resident in the hospital and rest home. Resources are available for staff use at any time. Residents are encouraged to maintain links with the community. There are church visitors, canine friends, guest speakers, entertainers and outings.</p> <p>The resident/family/whanau as appropriate completes a “Life experiences” information sheet. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. Resident meetings are held and are open to families to attend.</p> <p>D16.5d. The activity plans were reviewed at the same time as the clinical care plans in resident files sampled.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The written evaluation template describes progress against every goal and need identified in the care plan. Short term care plans were utilised and evaluated regularly (also link 1.3.6.1). Family were invited to attend the multidisciplinary review (MDR) meetings. The physiotherapist, GP, activity co-ordinator and care staff were involved in MDR meetings.</p> <p>D16.4a Care plans were evaluated six monthly.</p> <p>D 16.3c: All initial care plans sighted had been evaluated by the RN within three weeks of admission.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 August 2015. There is a planned maintenance schedule in place that includes the calibration of medical equipment and functional testing including chair scales and hoists (November 2014). There is minor renovation occurring in the hospital kitchen that is sufficiently secured from resident access. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. The service employs grounds and garden staff that maintain the external areas. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. There is an outdoor designated smoking area. Interview with the care assistants</p>

		indicated the hospital hoist is used for personal cares for the residents in the special care unit if required.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections were in place appropriate to the complexity of service provided. Individual infection report forms were completed for infections and kept as part of the resident files. Infections were included on a register and a monthly report completed by the infection control officer. Monthly data was reported to the combined infection control and health and safety meetings. Staff were informed through the variety of meetings held at the facility. The infection control programme was linked with the RAP. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There was a roto virus outbreak during September and October 2014 that was reported to public health services.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The policy identifies that restraint is used as a last resort. There were two hospital residents with the use of enablers (bedrails). The restraint co-ordinator maintains a monthly enabler register. A recent restraint audit identified the enabler/restraint register was not tabled at the restraint meetings. A quality improvement plan had been raised. Resident files sampled with enablers identified assessments and consents signed by the resident, GP and restraint co-ordinator. The restraint committee meets six monthly and reviews the use of enablers. Enablers and identified risks were documented on the long term care plan. There were three residents in the special care unit with chair brief restraints and one resident in the hospital with chair brief and lazy boy as restraints. Consents were in place and restraint documentation completed as per the policy. Restraint use is reviewed six monthly. Restraint use is included in orientation for clinical staff. An internal restraint audit identified the restraint co-ordinator appointed in November 2014 has not completed restraint induction (link 1.2.7.5). Challenging behaviour education has been provided.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Princess Alexandra was implementing the Ryman Accreditation Programme (RAP) which defines the meeting structure and agenda items. The RAP Committee meet monthly at Princess Alexandra with outcomes being reported across the various meetings including the full facility and clinical meetings. Clinical indicator data is reported through the monthly RAP meetings and full facility meetings. Resident meetings occur two monthly and relative meetings six monthly.</p>	<p>Clinical meetings are occurring two monthly, however meeting minutes do not consistently record discussion about resident incidents and possible trends. Resident meetings are two monthly, there were occasions where issues raised were not consistently recorded as being followed up at the subsequent meeting.</p>	<p>Clinical meeting minutes record discussion about clinical data and resulting trends. Resident meeting minutes document follow-up of issues from meeting to meeting.</p> <p>90 days</p>

<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>	<p>PA Low</p>	<p>The RAP prescribes the internal audit programme which was being implemented at Princess Alexandra. Quality Improvement Plans (QIP) are developed to address shortfalls across any monitoring process – for example, when an internal audit does not meet the prescribed threshold, when benchmarking data exceeds targets, where complaints received identify a trend and/or feedback from resident/relative surveys identify issues. Princess Alexandra had QIPs in place resulting from complaints, survey feedback, internal audit and clinical indicator data.</p>	<p>While a number of QIPs had regular monitoring reported on the prescribed form, and signed close out when resolved; there were a small number that had been generated in August (2014) that did not appear to have been monitored and closed out. Two in particular related to completion of induction and attendance at in-service education (also refer 1.2.7.5).</p>	<p>Quality Improvement Plans are monitored with recorded progress, and are evaluated and closed out when complete.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>There is an annual training plan aligned with the RAP that was being implemented. Attendance at education is entered into the Vcare system. In addition additional education is reportedly delivered opportunistically however no evidence of these sessions was sighted during the audit. There was an enrolled nurse overseeing staff participation in the ACE programme (compulsory care assistants) and the induction process. This role is 16 hours/week. The care assistant induction programme was being implemented with completion being reported monthly to head office as part of the RAP programme. Interview with care assistants informed the induction programme meets the requirements of</p>	<p>The annual training plan includes topics prescribed in the health and disability sector standards. Attendance at these sessions during 2014 were less than 50% attendance – for example: abuse and neglect – 11%, privacy/dignity – 31%, behaviour problems – 36%. The service was aware of the issue and a QIP was in place (refer 1.2.3.8).</p> <p>The prescribed induction programme for new care staff was seen to be current (and/or in progress). There are induction packages for key roles including registered/enrolled nurse, infection control, restraint, assistant manager, clinical manager. At the time of audit a completed induction package for the assistant manager, restraint coordinator and two food services staff were reportedly</p>	<p>Ensure an induction and training programme is fully implemented.</p> <p>90 days</p>

		the service.	<p>outstanding. All had been in roles for over three months.</p> <p>Care assistants working in the dementia unit are required to complete the dementia standards and the service is active in ensuring this occurs. Due to recruitment and retention matters, there is a moderate use of bureau staff across the service. Ryman caregivers are used to fill in any gaps in roster in dementia unit. There have been occasions when bureau have been used but the senior on duty has dementia qualifications and is buddied up with any bureau staff.</p>	
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Interview with the management team (clinical manager and assistant village manager) inform the service has experienced a relatively high staff turnover over the past year, some resulting from performance management. Recruitment is underway. Review of the rosters indicate sufficient staff numbers to meet resident numbers, including the use of bureau staff to cover unexplained absence. The service operates a mixture of full and short shifts and have two 'float' positions (1400-2200 and 2300-0700) that replace any short notice leave (sick leave) or are required to work in an area based on acuity.</p> <p>In the rest home wing there were 12 rest home residents and seven hospital level residents. The eight rest home level residents living in serviced apartments</p>	<p>Bureau staff have been used in the dementia unit to cover unexplained absence (nine shifts across December and January) and it is unclear if they are suitably qualified (refer 1.2.7.5), one of these shifts was a night duty (the provider reports bureau staff are buddied with a suitably qualified caregiver). It is noted at the time of audit there were two residents in the dementia unit requiring two person transfer (awaiting reassessment), review of rosters indicated staffing levels had not been increased to support the change in care needs. Interview staff informed there has been times when unplanned absence is not replaced.</p>	<p>Review skill mix based on resident acuity.</p> <p>90 days</p>

		are essentially monitored by the staff working in the rest home wing, with additional support being provided by the hospital wing staff if required. There are two care assistants based in the rest home wing overnight. In the hospital wing overnight there are three care assistants plus a 'float' position, and a registered nurse (there were 30 hospital level and 24 rest home level residents in the hospital wing). There were 23 (of 24) resident in the dementia unit with two care assistants overnight. There were at least two residents in the dementia unit at the time of audit that required a two person transfer (refer 1.3.3.3).		
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medication charts are clear, legible and meet the prescribing requirements for regular medications. As required medications have the date and time of administration on the signing sheet. D16.5.e.i 2; Thirteen out of 14 medication charts reviewed identified three monthly medication reviews signed by the GP.</p>	<p>(i) One medication chart had not been reviewed since August 2014. (ii) There were no indications for use for as required medications.</p>	<p>Ensure medication charts meet legislative requirements. Ensure medication practice complies with medication administration policy.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the</p>	<p>PA Moderate</p>	<p>D16.5e; Medical assessments were completed in all files within 48 hours of admission. Three monthly medical reviews were documented in all files by the general practitioner (GP). More frequent medical assessment/ review noted occurring in residents with acute</p>	<p>Referrals for re-assessment to higher level of care are made by the attending GP. Special care unit files were extended from two to five to determine if timely assessments for residents with declined mobility were being undertaken. Three of five resident files indicated the resident</p>	<p>Ensure timely GP referrals and re-assessments occur for residents with declining health and mobility status.</p>

<p>consumer.</p>		<p>conditions. The contracted GP is currently on leave and a locum has been provided to continue with weekly visits and as required for resident concerns. Residents may retain their own GP. There is evidence of timely GP responses to RN fax/phone calls for clinical concerns. The GP was unavailable for interview on the day of audit.</p>	<p>needs (from progress notes and GP medical notes) and supports had increased as follows; (i) one resident had become chair bound requiring two person transfers. GP notes state the resident is for comfort cares. The resident was observed being cared for in a lazy boy chair and bed. A needs assessor had completed an assessment. Approval for hospital care was received on day of the audit. (ii) The second resident had reduced mobility requiring two person transfers as per progress notes. The GP notes state "refers for higher level of care". This was actioned on day of audit. (iii) The third resident file identified a GP delay in re-assessment and medication review (as recommended by the psychiatrist) for a rest home resident with challenging behaviour. This necessitated an urgent transfer to special care unit for resident safety. There is documented evidence of on-going RN requests for GP review for this resident. The referral was followed up on the day of audit.</p>	<p>60 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Risk assessment tools were sighted as completed and reviewed at least six monthly or when there was a change to a resident's health condition. Monitoring forms in place included (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts and nutritional assessments.</p>	<p>Care plans do not reflect the resident's current health status for the following; (i) There were no documented interventions for rest home resident in the serviced apartment with recurrent epistaxis; (ii) One hospital resident was assessed as high risk of pressure areas. The outcome of the assessment is not reflected in the care plan for example the use of an air alternating mattress. (iii) The behavioural care plan has not been reviewed for</p>	<p>Ensure interventions are documented to reflect the resident's current needs, health and mobility status. 30 days</p>

			<p>another hospital resident with challenging behaviours six monthly.</p> <p>Care plans have not been updated to reflect the current health and mobility status in five of five special care resident files sampled. One of the five residents was urgently transferred to the special care unit. There was no review of the care plan on transfer.</p>	
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.