

# Ryman Napier Limited - Princess Alexandra Retirement Village

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## 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:

<b>Legal entity:</b>	Ryman Napier Limited
<b>Premises audited:</b>	Princess Alexandra Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 26 June 2018    End date: 27 June 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	109

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Princess Alexandra is a Ryman healthcare retirement village, which provides care for up to 108 residents in the care centre at hospital, rest home and dementia level care and rest home level of care across 30 serviced apartments. At the time of the audit there were 109 residents in total.

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 in this role for two years. An assistant manager and clinical manager support the village manager. The residents and family members interviewed spoke positively about the care and support provided.

The service has been awarded continuous improvements ratings around their quality system and end-of-life care.

## 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.

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 is 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.		Standards applicable to this service fully attained.
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Initial assessments and risk assessment tools are completed by registered nurses on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe. Monitoring forms are available. Care 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 visits residents at least three monthly. There are activity diversional therapists in each unit to provide an activity programme to ensure the abilities and recreational needs of the residents is varied, interesting and involves the families and community. There are 24-hour activity plans for residents in the dementia care unit that are individualised for their needs. 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. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents in the dementia care unit. 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.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were two residents with enablers and three residents with restraints 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.
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The infection control coordinator/clinical manager 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. Staff receive ongoing training in infection control.

## 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)
<b>Standards</b>	1	16	0	0	0	0	0
<b>Criteria</b>	2	40	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 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 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 service delivery complaints. The facility has an up-to-date complaint register for each unit.</p> <p>Concerns and complaints are discussed at relevant meetings. The complaints process is linked to the quality and risk management system. Fifteen complaints have been received since the last audit, four complaints received in 2016, eight complaints made in 2017 and three complaints received in 2018 year-to-date. All complaints reviewed have been managed in a timely manner and are documented as resolved. One of the complaints made in 2018 was received through the district health board (DHB) and the provider completed internal investigations with no further action required.</p>
Standard 1.1.8: Good Practice	CI	Ryman Healthcare has a teamRyman programme that includes annual planning and

<p>Consumers receive services of an appropriate standard.</p>		<p>a suite of policies/procedures. Policies are reviewed at an organisational level. These documents have been developed in line with current accepted best and/or evidence-based practice and are reviewed regularly. Services are provided at Princess Alexandra that adhere to the health &amp; disability services standards. An implemented quality improvement programme includes performance monitoring. There are human resources policies/procedures to guide practice and an annual in-service education programme that is incorporated into the team Ryman programme.</p> <p>The in-service programme at Princess Alexandra is being implemented. There is a journal club for registered nurses (RN) and enrolled nurses (EN) held bi-monthly in conjunction with the RN/EN clinical meetings. There are competencies for caregivers and qualified nurses. Core competency assessments and induction programmes are in place at Princess Alexandra. Registered nurses have access to external training. Residents and relatives interviewed were positive about the care they receive. The service has been successful in delivering quality end of life care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Five residents (three rest home and two hospital) 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. Twelve incident forms reviewed evidenced the family had been informed of an accident/incident. Four relatives (two hospital and two dementia care) interviewed, stated that they are informed when their family members health status changes.</p> <p>Two monthly resident and six monthly relative meetings provide a forum for residents and families to discuss any issues or concerns. Specific introduction information is available on the dementia unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Princess Alexandra Retirement Village is a Ryman Healthcare facility, situated in Napier. The service provides care for up to 108 residents in the care centre at hospital, rest home and dementia level care. There are also 30 serviced apartments certified to provide rest home level of care. Sixty beds within the care centre are dual-purpose. At the time of the audit, there were 109 residents in total, 105 residents in the care centre and four rest home residents in the serviced apartments. The care centre residents included 34 rest home (12 in the dual-purpose beds), including one resident on respite care and one resident on an intermediate care bed</p>

		<p>(ICB) contract funded by the DHB, 48 hospital residents (all in dual-purpose beds), including two residents on ACC funded contracts. There were 23 residents in the dementia care unit. All other residents were under the aged related residential care (ARRC) contract.</p> <p>Ryman Healthcare has an organisational business and quality management plan. Quality objectives and quality initiatives are set and reviewed annually. The village quality objectives and quality initiatives for 2017 have been reviewed with achievements around implementation of a cover pool of staff for unplanned absences, introduction of a training squad to orientate staff to facility and work areas and election of health and safety committee members representative of each area. The village objectives for 2018 have been discussed at full facility meetings.</p> <p>The village manager is a RN who has been in this role for two years. She was in the clinical manager role for three months prior to the village manager role. A full-time assistant manager and clinical manager support the village manager. The assistant manager has been in the position for four years and the clinical manager has been in the role for nine months. They are supported by four unit-coordinators in each area. Management are also supported by a regional operations manager and clinical practice and audit manager (at head office).</p> <p>The village manager has maintained at least eight hours of professional development activities related to managing an aged care service. The clinical manager has completed ongoing training via the orientation/induction programme, RN modules and in-service programme.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Princess Alexandra 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, infection control and health and safety meetings) and reported to the organisation's management team. Discussions with the management team (village manager, assistant manager and clinical manager) and staff, and review of meeting minutes demonstrate their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Annual resident and relative surveys are completed annually. Results and any areas for improvement are fed back to staff and participants through meetings and village reports to relatives. At the time of the audit the results for the 2018 resident and relative satisfaction surveys had not been analysed and completed.</p> <p>The service has policies, procedures, and associated implementation systems to</p>

		<p>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.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (administrator) 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. The service continues to maintain a continued improvement approach/outcome in relation to falls reduction.</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>	<p>FA</p>	<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 12 incident/accident forms from across all areas of the service, identified they all are fully completed, including follow-up by a RN and relative notification. Post-falls assessments included neurological observations for three unwitnessed falls 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.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities. There have been two section 31 notifications completed since the last audit, one for a resident's behaviour in August 2017 and one for a missing</p>

		resident in April 2018. A respiratory outbreak in February 2018 was reported to the public health authorities (link 3.5).
<p><b>Standard 1.2.7: Human Resource Management</b></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. Seven staff files reviewed, (including one clinical manager, two unit-coordinators [hospital and rest home], one RN, two 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 RNs and health professional practising certificates are maintained. An orientation/induction programme provides new staff with relevant information for safe work practice. There is an annual education plan in place for 2018. The assistant manager maintains education, and maintains attendance training records. Additional toolbox sessions are provided.</p> <p>Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session. Registered nurses are supported to maintain their professional competency. There are currently 14 RNs working at Princess Alexandra and eight RNs are interRAI trained. Thirteen caregivers work in the dementia unit. Seven of thirteen caregivers have completed their dementia unit qualification. There are six caregivers in the process of completing units. All six caregivers have commenced work within the last 12 months. Completion of the induction programme and required dementia standards are monitored and reported monthly to head office, as part of the teamRyman programme.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The village manager and clinical manager, work full time and are on call 24/7. Each service unit in the care centre has a RN unit coordinator. Interviews with seven caregivers (two rest home, two hospital, two dementia care and one serviced apartment) 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.</p> <p>Staffing at Princess Alexandra is as follows; in the rest home unit (24 beds; 22 rest home residents) there is one RN unit-coordinator or RN on duty with three caregivers (two full and one short shift) on the morning shift, two caregivers on the afternoon shift and one caregiver on night shift. In the hospital unit (60 dual-purpose beds; 48 hospital residents and 12 rest home residents) there is a RN unit coordinator with two</p>

		<p>RNs on duty in morning and afternoon shifts and one RN on night shift. There are 12 caregivers (seven full and five short-shifts) on the morning shift, ten caregivers (five full and five short-shifts) and three caregivers on night shift.</p> <p>In the dementia care unit (24 beds; 23 dementia residents) there is a RN unit coordinator with two caregivers on the morning shift, three caregivers (two full and one short shift) on the afternoon shift and one caregiver on night shift. The RNs in the hospital cover the rest home and dementia care units on the afternoon and night shifts. In the serviced apartments (four rest home residents), there is a unit coordinator or senior caregiver with two caregivers on the morning and afternoon shifts with staggered finishing times until 9.00 pm. The caregivers and RN in the hospital cover the serviced apartments at night.</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 policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medications are stored safely in all three units (rest home, hospital and dementia care). Medication reconciliation of monthly blister packs is completed by an RN and the blister signed. All medications including hospital bulk supply medications were within the expiry dates. Registered nurses and senior care assistants who administer medications have been assessed for competency. The service uses an electronic medication system. Medication fridges are monitored weekly.</p> <p>All eye drops and creams in medication trolleys were dated on opening. There was one hospital level resident (intermediate care resident) who was self-medicating and had a self-medication competency in place. Fourteen medication charts were reviewed across all units on the electronic medication system. All medication charts had photographs and 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.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by a second chef, chef assistant and dishwasher each shift. All staff have been trained in food and chemical safety. The food control plan was submitted May 2018. Project "delicious" provides menu choices including a vegetarian option each meal. The main meal is at midday. The menu has been reviewed by a dietitian March 2018. Menu choices are decided by residents (or staff if the resident is not</p>

		<p>able) and ordered in advance. Special diets such as gluten free is provided, and dislikes are accommodated. Modified diets are provided. Meals (in bain marie pots) are delivered in hot boxes to the unit kitchens and served from bain maries in the kitchenettes. Serving temperatures are taken and recorded in all units.</p> <p>Nutritious snacks are available 24 hours in all units. The clinical manager informs the head chef of residents with weight loss and dietitian input to diets. A daily food control plan is completed including freezer and chiller temperatures, end-cooked temperatures and inward goods temperatures. All foods were date labelled. 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, surveys and direct contact with the food services staff. There is a comments book in each dining room that is checked by the head chef. Residents and relatives interviewed spoke positively about the choices and meals provided.</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>	<p>FA</p>	<p>Rest home and hospital level residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the RN initiates a review and if required a GP visit or nurse specialist consultant. Electronic care plans reflect the required health monitoring interventions for individual residents. The myRyman electronic system triggers alerts to staff (caregivers and RNs) when monitoring interventions are required. These are automatically generated on the electronic daily work schedule for the caregiver and RN to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (eg, resident turns, fluids given). Monitoring charts are well utilised. Changes are updated on the relevant electronic care plan which is automatically transferred into the myRyman care plan.</p> <p>Wound assessments, treatment and evaluations on the electronic resident system were in place for a sample of eight residents with wounds that were reviewed (six hospital, one rest home and one dementia care). When wounds are due to be dressed, a task is automated on the RN daily schedule. There were three hospital residents with stage two pressure injuries (two facility acquired and one on admission). The facility has an RN coordinator who is the wound champion. There is also access to wound specialist nurses if required. Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p>

<p><b>Standard 1.3.7: Planned Activities</b></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>	<p>FA</p>	<p>The team of activities staff (two with diversional therapy qualifications, one activities coordinator, one activity assistant and a casual DT) provide activities across the units. There is a seven-day programme in the dementia care unit and hospital unit and Monday to Friday in the rest home. The Engage activities programme is implemented across the rest home, hospital, dementia unit and serviced apartments. Rest home residents in serviced apartments can choose which programme they would prefer to attend. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple A exercises, news and views, sing-a-longs, themed events and celebrations, baking, knitting, arts and crafts, sensory activities. Canine pets coming to visit, outings and drives.</p> <p>A facility van is available for outings for all residents. Volunteers include Duke of Edinburgh students, girl guides, guest speakers, entertainers and church services. The lounge areas in each unit have seating placed for large and smaller group activities. One-on-one activities occur, as well as regular walks and wheelchair walks out in the gardens. Daily contact is made with residents who choose not to be involved in the activity programme. Residents in the dementia care unit have the freedom to wander out into the safe gardens and ground (as weather permits). Activities are flexible to the residents' abilities on the day, and include music, entertainers, pet therapy, van outings, triple A exercises twice a day, memory lane and group games. The men's club have been involved in building and painting bird boxes.</p> <p>Residents are invited to activities and entertainment in other units as appropriate and under supervision. Resident life experience assessments are completed for residents on admission. The activity plan in the resident files 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 provide feedback on the programme through the resident and relative meetings and satisfaction surveys. Residents and relatives interviewed commented positively on the activities provided. In the two dementia-care level myRyman activity plans reviewed, all the information around activities to engage or distract residents over the 24-hour period were documented.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term resident files reviewed on the electronic resident system identified that long-term care plans had been evaluated by RNs regularly and at least six-monthly. Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care</p>

		<p>plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review.</p> <p>There is also a multidisciplinary (MDT) review completed that includes people involved in the resident's care. Records of the MDT review were evident in the resident files reviewed. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed, confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 1 August 2018. There is a reactive and planned maintenance programme. There is new nurse's hub and sensory/quiet lounge currently being constructed in the dementia unit. This is safely blocked off until completed. Construction workers have reduced noise to a minimum and are sensitive to the residents needs.</p>
<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 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. Infections are included on an electronic register and the infection control coordinator (clinical manager) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. 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.</p> <p>A respiratory outbreak (February 2018) was reported to relevant authorities. This was contained to the hospital level unit. Documentation including case logs were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	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 include definitions, processes and use of restraints and enablers. On the day of audit there were two residents with enablers (bedrails). There was evidence of voluntary consent in the two enabler resident files reviewed. There were three residents with restraint in use (all bedrails). Staff training has been provided around restraint minimisation.</p>



## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has reviewed and implemented a quality initiative for residents at end-of-life including supporting the family during the dying process and death of their loved one. Feedback from families' evidences the service has been successful in providing a supportive environment for them and their loved one.</p>	<p>Princess Alexandra management and staff worked closely with Cranford Hospice to achieve their quality initiative goals. An action plan included an interdisciplinary approach to care with the GP and hospice, continual and effective communication with families including preparing families around the dying process, symptom control ensuring residents are pain free, comfortable and relaxed, learning and education for staff, debriefing sessions for staff after residents have passed away and the implementation of a palliative care trolley for families. A palliative nurse champion completed training at the hospice to provide support to staff and families.</p> <p>Three RNs and six caregivers have completed the Advanced Palliative Care certificate with Cranford Hospice. The palliative care trolley has been effective in helping families feel more comfortable</p>

			and has items to help families take care of themselves and care for the residents if they wish. The RN presented “When is a trolley not just a trolley” at the recent ARC mini-conference celebrating palliative care. Letters of thanks for the wonderful care were sighted. The palliative care trolley was evidenced to be in use during the audit 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>	CI	<p>Robust systems are in place for the collection, analyses, and evaluations of quality data. A range of data is collected around falls, skin tears, pressure injuries, and infections across the service through myRyman. 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. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (eg, management, full facility and clinical/RN meetings). Templates for all meetings document action required, timeframe, and the status of the actions.</p>	<p>Falls were identified as an area that required improvement from data collected from February to July 2017. A continuous improvement plan was developed in August 2017, which included identifying residents at risk of falling, 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, reviewing of clinical indicator data, the use of sensor mats, proactive and early GP involvement, and increased staff awareness of residents who are at risk of falling.</p> <p>The plan has been reviewed monthly and discussed at management, staff and clinical meetings. Education and training for staff has been provided in 2017 and for new staff as part of orientation. Caregivers interviewed were knowledgeable in regard to preventing falls and residents who were at risk. The evaluation and outcome of the continuous improvement plan has been that the rate of falls for dementia residents reduced to an average of 7.74 per 1000 bed nights for the period from August 2017 to January 2018, the rate of falls for the period from February to July 2017 were at an average of 9.29 per 1000 occupied bed nights.</p>

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End of the report.