

# Ryman Napier Limited - Princess Alexandra Retirement Village

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: 1 July 2021      End date: 2 July 2021
<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>	104

# 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 part of the Ryman Group of retirement villages and aged care facilities. The service provides rest home, hospital and dementia levels of care for up to 108 residents in the care centre, and rest home level of care for up to 30 residents in serviced apartments. On the day of audit, there were 104 residents.

An experienced village manager who is a registered nurse and an experienced clinical manager who is also a registered nurse manage the service. There are quality systems and processes being implemented. The service continues to actively work on reducing the incidents of falls. An induction and in-service education programme is in place to provide staff with the appropriate knowledge and skills to deliver care. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, general practitioner and staff.

There are three areas of continuous improvement awarded around maintaining a low incidence of falls, food services and maintaining a restraint-free environment.

## 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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Princess Alexandra provides care in a way that focuses on the individual resident's quality of life. There is a Māori health plan and implemented policy supporting practice. Cultural assessments are undertaken on admission and during the review process. Policies are being implemented to support individual rights, advocacy and informed consent. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is readily available to residents and families. Care plans reviewed accommodated the choices of residents and/or their family. Complaint processes are being implemented and complaints and concerns are managed appropriately. Residents and family interviewed verified ongoing involvement with the community.

## 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.
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Princess Alexandra is implementing the teamRyman programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the various facility meetings and to the organisation's management team. Princess Alexandra provides clinical indicator data for the three services being provided (hospital, rest home and dementia care). 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

education/training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. The general practitioner or nurse practitioner completes an admission visit and reviews the residents at least three-monthly.

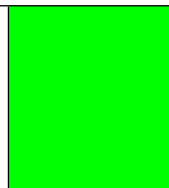
The activity team provides an activities programme which is varied and interesting for each resident group. The engage programme meets the abilities and recreational needs of the group of residents including outings.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three monthly.

The menu is designed by a dietitian at an organisational level. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours.

## 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. Chemicals were stored safely throughout the facility. All bedrooms in the rest home and hospital areas are single occupancy with ensuites, with shared communal facilities in the special care (dementia) unit. There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. There are policies in place for emergency management. There is a person on duty at all times, with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

## Restraint minimisation and safe practice

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



Standards applicable to this service fully attained.

There is a restraint policy in place with associated procedures and forms. The policy contains definitions of restraint and enablers that are congruent with the definitions included in the standards. The restraint coordinator oversees restraint/enabler usage within the facility. The service currently has no residents using restraints and one resident voluntarily using bedrails as an enabler. Staff regularly receive education and training in restraint minimisation and managing behaviours that challenge.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team hold monthly meetings and feed in to both registered nurse and general staff meetings. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed. There was one suspected outbreak in May 2020 which was reported to the public health unit as a precaution, however negative test results were returned.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	3	90	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information related to the Code is made available to residents and their families. Three managers (one village manager, one clinical manager, one regional manager) and twenty-eight staff (one assistant to the manager, three unit coordinators/registered nurses (RNs), seven staff RNs; one enrolled nurse (EN), seven caregivers working on the AM and PM shifts (three rest home level with one from the serviced apartments, two hospital and two dementia care), two activities staff, one maintenance, two chefs, two housekeepers (one who is also the health and safety representative), two laundry staff) confirmed their understanding of the Code and its application to their specific job role and responsibilities. Staff receive training about the Code, which begins during their induction to the service. This training continues through the mandatory staff education and training programme, which includes competency assessments.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in eleven resident files (six hospital including one ACC resident, three rest home including one resident in the serviced apartments and one respite, and two dementia care) were signed by the resident or their enduring power of attorney (EPOA).</p>

<p>of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members evidenced that the service actively involves them in decisions that affect their relative's lives.</p> <p>Nine resident files of long-term residents have signed admission agreements and the ACC and respite care residents had signed short-term agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access the Health and Disability Commission (HDC) independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p> <p>One complaint lodged in 2021 reflected evidence of the involvement of HDC advocacy services. This complaint has been documented by HDC advocacy as being resolved.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities for residents to attend events outside of the facility. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy is being implemented. The village manager has overall responsibility for ensuring all complaints (verbal and/or written), are fully documented and investigated. The facility maintains up-to-date complaints register. Concerns and complaints are discussed at relevant meetings.</p> <p>Six complaints were lodged in 2020 and six in 2021 (year-to-date). An acknowledgement of each complaint, investigation and outcome is documented. All but one complaint, lodged with the HDC office (26 March 2021), have been documented as closed/resolved. In regard to the complaint lodged through HDC, requested information has been sent to the HDC office within the timeframe required and the facility is awaiting further feedback by HDC. A quality improvement plan (QIP) implemented as a result of this complaint includes the review of policy around transporting residents, and education of staff.</p>

		Discussions with residents and relatives confirmed they were provided with information on the complaints process.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Interviews with six residents (two hospital, four rest home) and eight relatives (one hospital, one rest home and six dementia) confirmed they were provided with information on admission which included information about the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The village manager confirmed her door is open to visitors. Both she and the clinical manager described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ryman has policies that support resident privacy and confidentiality. A tour of the Princess Alexandra facility confirmed there were areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process with family involvement. Interviews with care staff described how choice is incorporated into resident cares. Staff have been provided with training on abuse and neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori.  A cultural village objective has been set by Princess Alexandra to educate staff on the importance of cultural diversity, ensuring the needs of Māori residents are met. Links are established with local iwi and other community representative groups as requested by the resident/family. Efforts are underway by the village manager to organise additional staff cultural training through the DHB. The activities team incorporates Māori language into their day-to-day activities and Māori residents (one resident at the time of the audit) are greeted in te reo.  Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Residents who identify as Māori have this recorded in their care plan and cultural needs are documented. One family member of a resident who identifies as Māori confirmed that the resident's values and beliefs

		are being upheld by the service.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care-planning meeting is carried out where the resident and/or whānau, as appropriate/able, are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed values and beliefs are considered. Residents interviewed confirm that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities and staff sign a copy during the employment process. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with the managers and staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which are developed in line with current accepted best practice, and these are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A range of clinical indicator data are collected against each service level and reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the team Ryman programme. Quality improvement plans (QIP) are developed where results do not meet expectations or non-conformances are identified.</p> <p>The latest resident satisfaction survey (Feb 2021) reflects high levels of resident satisfaction that is above the Ryman benchmark and is slightly improved from the 2020 results (from 4.58 out of a possible score of five to 4.65).</p> <p>An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch. A physiotherapist is onsite three days a week (12 hours) with additional support from a physiotherapy assistant who is available five days a week (20 hours). A general practitioner (GP) from Third Age Health visits the facility twice a week and is supported by a nurse practitioner who visits one day a week. The practice also provides on-call cover if after hours.</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>There is an incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. Fifteen incidents reviewed on the VCare (electronic) system indicated that family are kept informed. Family members interviewed confirmed they are notified following a change of health status of their family member and/or following an adverse event. Resident meetings are held two monthly and family meetings are scheduled six-monthly. There is an interpreter policy and contact details of interpreters are available. This has not been required since the previous audit.</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 is able to provide rest home, hospital and dementia levels of care for up to 108 residents in the care centre. Sixty beds within the care centre are suitable for rest home or hospital levels of care. There are also 30 serviced apartments that have been certified to provide rest home level of care.</p> <p>There were 101 residents in the care centre and 3 rest home level residents in the serviced apartments at the time of the audit. The care centre residents included 23 rest home residents, 54 hospital residents, and 24 residents in the dementia unit. One hospital level resident was on ACC and four residents were on respite (three hospital and one dementia). The remaining residents were under the age-related residential care agreement.</p> <p>Ryman Healthcare has an organisational total quality management plan and a policy outlining their purpose, values and goals. Princess Alexandra has set annual quality objectives. Evidence was sighted to confirm objectives for 2020 and 2021 (year-to-date) have been reviewed. Outcomes are reported to the regional manager and to staff, evidenced in meeting minutes.</p> <p>The village manager is an RN who has been in this role for six years. She holds a post graduate certificate in long term conditions. A full-time clinical manager supports the village manager. The clinical manager has been in the position since January 2021 and has worked in aged care since 2008. An assistant to the manager, unit coordinators, senior RNs, a regional operations manager and advisors at Ryman Christchurch support the managers.</p> <p>The village manager has completed over eight hours of professional development relating to the management of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the</p>	<p>FA</p>	<p>Ryman policy outlines village manager availability, including on call requirements. During a temporary absence, the assistant to the manager and clinical manager cover the village manager's role. The regional operations manager provides oversight and support.</p>

<p>day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<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>Ryman Princess Alexandra continues to implement a robust quality and risk management programme, which links key components of the Ryman quality management system to village operations. There are a range of meetings that take place (monthly full facility meetings, monthly team Ryman (quality) meetings, two monthly resident meetings, six monthly family meetings, monthly health and safety meetings and monthly clinical meetings). Outcomes and quality improvement plans (QIPs) are reported across the various meetings, evidenced in the range of meeting minutes reviewed. Interviews with staff confirmed their understanding of the quality programme.</p> <p>Policy review is coordinated by Ryman Christchurch. Policy documents have been developed in line with current best and/or evidenced based practice. Staff are informed of changes/updates to policy at relevant staff meetings. In addition, a number of core clinical practices are covered in staff competency assessments that staff are required to complete. Staff stated they are made aware of any new/reviewed policies and these are available in the staff room.</p> <p>Relative and resident surveys were last completed in February 2021. Results have been collated with annual comparisons for each service. Improvements were noted when compared to 2020 and no areas were identified that required the implementation of a QIP. Residents and relatives are informed of the outcomes of surveys in the resident and relative meetings. An annual internal audit schedule is being followed as per the schedule. Internal audit summaries and QIPs are completed where a non-compliance is identified.</p> <p>Monthly clinical indicator data is collated across the care centre (including rest home residents in the serviced apartments). There is evidence of trending of clinical data, and development of QIPs when volumes exceed expected targets. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A gradual reduction in falls resulting from the implementation of a range of strategies has resulted in a rating of continuous improvement.</p> <p>Health and safety policies are implemented and monitored as evidenced in the monthly health and safety meetings. The village manager has overall responsibility for the health and safety programme. A health and safety representative (cleaner) was interviewed during the audit. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. The hazard registers for generic and specific hazards are reviewed a minimum of annually. The</p>

		<p>internal audit programme is linked to health and safety (e.g., food safety audits, emergency call bell audits, environmental audits, fire safety audits, waste management audits). Staff document hazards and near miss events in a designated book that is held at reception. All staff complete health and safety training during their induction to the facility. Reception staff and/or maintenance staff are responsible to orientating external contractors through the Assure electronic system.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Princess Alexandra collects monthly incident and accident data and completes electronic recording of events on the VCare system. Monthly analysis of incidents by type is undertaken by the service and is reported to the various staff meetings. Fifteen accident/incident assessments reviewed (unwitnessed and witnessed falls, skin tears, pressure injuries) reflect an RN assessment and post falls neurological observations for unwitnessed falls and any suspected injury to the head. Follow-up is by an RN and sign-off is indicated by the clinical manager's electronic signature.</p> <p>The village manager and clinical manager are aware of the situations that would require notification to relevant authorities in relation to essential notifications. Section 31 notification forms are completed for any stage three or unstageable pressure injury. The DHB has been informed regarding the complaint lodged with HDC. The facility was authorised by HealthCERT to keep a resident in a higher (D6) level of care until 5 March 2021 when suitable placement was available. Notifications to relevant public health authorities and the DHB were also sighted for an (unsubstantiated) infectious outbreak in May 2020.</p>
<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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (one unit coordinator/RN, five caregivers, three kitchen assistants, two activities coordinators, one laundry staff, two housekeepers) included a signed employment contract, job description, police check, induction paperwork relevant to the role the staff member is in, application form and reference checks. Files reviewed of employees who have worked for one year or more included evidence of annual performance appraisals. A register of RN and enrolled nurse (EN) practising certificates are maintained. Current practising certificates for other health practitioners (e.g., GP's, nurse practitioner, physiotherapists, podiatrist, pharmacists) were also sighted.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. Educational courses offered include in-services, competency questionnaires, online learning and external professional development. There is an attendance register for each educational session and an individual staff member record of training that reflects staff attending eight hours or more per annum.</p> <p>Approximately 80 caregivers are employed. Seventeen have achieved their level three (or equivalent) Careerforce qualification and seven have achieved their level four qualification (or higher). Nineteen</p>

		<p>caregivers work in the dementia unit. Eleven caregivers have completed an approved dementia qualification. Eight caregivers are progressing through their dementia unit standards and have been employed for less than eighteen consecutive months.</p> <p>Registered nurses are supported to maintain their professional competency. RNs attend regular (two-monthly) journal club meetings. There are implemented competencies for RNs, EN and caregivers related to specialised procedures and/or treatments including (but not limited to) infection control, medication and insulin competencies. At the time of the audit there were 21 RNs and one EN employed at Ryman Princess Alexandra. Fourteen RNs (including the clinical manager) have completed interRAI training.</p>
<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>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, and assistant to the manager work Monday – Friday and the clinical services manager/RN is rostered Tuesday - Saturday.</p> <p>The hospital wing (occupancy 54 hospital, 2 rest home) is staffed with a unit coordinator/RN Sunday – Thursday with the clinical manager covering the hospital wing on Fridays and Saturdays. Three RNs cover the AM shift, and two RNs are rostered on the PM shifts. One RN is rostered for the night shift. The AM shift is staffed with six long shift and six short shift caregivers, the PM shift is staffed with four long shift and six short shift caregivers and the night shift is staffed with three long shift caregivers. Activities staff are rostered seven days a week from 9:30 am – 4:30 pm. One fluid assistant covers the AM shift (short shift) seven days a week.</p> <p>The dementia unit (occupancy of 24 residents) is staffed with a unit coordinator/RN during the AM shift (Tuesday - Saturday) and a staff RN on Sunday and Monday. The AM and PM shifts are staffed with two long and one short shift caregivers. The night shift is staffed with two long shift caregivers.</p> <p>The rest home wing (occupancy 21 rest home level residents) is staffed with a senior caregiver seven days a week on the AM shift. The AM, PM and night shifts are staffed with two long shift caregivers on each shift.</p> <p>Service apartments (three rest home level residents) is staffed with one-unit coordinator/RN Sunday - Thursday. A senior caregiver is rostered on the two days that the unit coordinator is not available. In addition, the AM shift is staffed with two short shift caregivers. The PM shift is staffed with two short shift caregivers to 9.00 pm. After 9.00 pm, a designated caregiver in the rest home wing covers the serviced apartments via a pager system. Any rest home level residents in the serviced apartments are clearly identified on the resident register and are communicated to the senior rest home level caregiver during handover.</p>



		<p>A 'cover pool' of staff (RN cover 88 hours per week, caregiver cover 137.5 hours per week) are additional staff that are added to the roster to cover staff absences. Two ENs are employed who work in the capacity of a senior caregiver (one in dementia and one in the serviced apartments).</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported that there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record using an electronic database referred to as 'My Ryman'. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access. Care plans and notes are legible and where necessary signed (and dated) by a RN. Progress notes reviewed were dated and signed by the relevant carer. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. The service has a well-developed information pack available for residents/families/whānau at entry. Specific information about the dementia unit (SCU) is provided to families. Family members report that the village manager, assistant village manager or clinical manager are available to answer any questions regarding the admission process</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term and short-term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made in a timely manner.</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>	<p>FA</p>	<p>Twenty-two medication files were sampled. There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit, standing orders are not used and no vaccines were stored on site.</p> <p>All required medication checks have been completed. Eye drops viewed in medication trolleys had been dated once opened. Resident's medicines are appropriately and securely stored in accordance with relevant guidelines and legislation. Medication fridge and room temperature checks are conducted, recorded and all within the required ranges.</p> <p>Medication administration practice complies with the medication management policy for the medication rounds sighted. Registered nurses, enrolled nurses and medication competent caregivers administer medicines, and sign for this electronically. All staff administering medicines have received medication management training and successfully completed a medication competency which is reviewed annually. Registered nurses have syringe driver training completed by the hospice.</p> <p>The facility uses a blister packed medication management system for the packaging of all tablets. Registered nurses reconcile the delivery of new medication and document this in the electronic system. There is evidence of three-monthly reviews by the GP. There was photo identification and allergy status recorded.</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>	<p>FA</p>	<p>The meals at Ryman Princess Alexander are all prepared and cooked on site. The kitchen was observed to be clean, well-organised and a current approved food control plan was in evidence. There is a four-week rotating seasonal menu that is designed and reviewed by a registered dietitian at an organisational level. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods, allergies) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen and in the serveries. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. The food control plan expires 9 May 2022. Meals are transported in hot boxes to the three-unit kitchenettes.</p> <p>The residents interviewed were very satisfied with the ongoing changes in the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident</p>

		meetings and through resident surveys.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Initial interRAI assessments and reviews are evident in printed format in all resident files. Resident files reviewed identify that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint (if appropriate), are completed according to need in a timely manner. For the resident files reviewed, the outcomes from assessments and risk assessments are accurately reflected in the care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The resident care plans in myRyman are personalised and describe the resident's goals, supports and interventions required to meet those desired goals, as identified during the ongoing assessment process. The care plan acknowledgement form evidences resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview that they and their families are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. All long-term care plans sampled have been reviewed and updated in a timely manner following a change in need. Integration of records and monitoring documents are well managed.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed</p>	FA	Registered nurses (RNs), enrolled nurses and caregivers, follow the care plan detailed on myRyman and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the dietician, physiotherapist or wound care specialist nurse). If external medical advice is required, this will be actioned by the GP and/or NP. Staff have access to sufficient medical supplies (e.g., dressings). Continence products are available and resident files include a three-day continence assessment and plan as part of the plan of care. Specialist

needs and desired outcomes.		<p>continence advice is available as needed and this could be described.</p> <p>Wound assessment, treatment and wound management plans are completed for all wounds. On the day of audit there were thirty-two wounds. These included: eleven skin tears, thirteen lesions (BCC/SCC), one laceration, two abrasions, three classed as 'other' (dermatitis, blister etc.) and one resident with two non-facility acquired grade 2 pressure injuries. All wounds have been reviewed within appropriate timeframes. All wounds evidence progress towards healing with the exception one of the chronic lesions. Wound nurse champion and GP and/or NP input is evidenced for all wounds, with referral to other allied health professional as required, including DHB wound nurse specialist.</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p> <p>Neurological observations were taken for all unwitnessed falls within the timeframes outlined by Ryman policy.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A review of the activity programme confirms that independence is encouraged, and choices are offered to residents. The ten activity and lifestyle coordinators at Ryman Princess Alexandra deliver the 'engage' programme, five of whom are qualified diversional therapists. The programme is delivered over seven days per week in the hospital and special care unit, and five days in the rest home, with activity resources being left set up on trolleys for resident and family to use as required. A wide range of activities which support the abilities and needs of residents in the facility are provided, including set themes and 'triple A' exercises, with each unit can then further add to and adapt according to resident preference and need. Residents who do not participate regularly in the group activities, are visited for one-on-one sessions which can include chats, word games, assisted walks and pampering sessions. All interactions observed on the day of the audit evidenced engagement between residents and the activity and lifestyle coordinator</p> <p>On admission, an activity and lifestyle coordinator completes an assessment for each resident and a resident life experiences form which are utilised as part of the care planning process. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition change) as part of the care plan evaluation/review. In the dementia files reviewed, residents have a 24-hour activity plan that document activities that can be utilised to de-escalate challenging behaviours, which are specific to individual residents.</p> <p>Activities across the service include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. Examples of activities incorporated into the programme are news and</p>

		<p>views, happy hour, church services and K9 friends pet therapy. The service also has a men's group, knitting circle and lady's lounge discussion group. Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities such as pampering sessions according to their preferences.</p> <p>Community links are maintained through visiting entertainers, various religious denomination visitors and weekly van trips, including the use of wheelchair accessible transport for those residents requiring it.</p> <p>Residents and family interviews confirm they enjoy the variety of activities and are very satisfied with the activities programme.</p> <p>A monthly meeting is held where residents and relatives have input. Minutes are recorded at the meeting and quality improvements identified and feedback given</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed have been evaluated six-monthly by a registered nurse. Care plans are evaluated to record progress towards achievement of the desired goals. Acute care needs are documented in myRyman and evaluated as needed. The six-monthly multidisciplinary review involves the RN, GP/NP, activities staff, physiotherapist (if involved) and resident/family.</p> <p>Family members are invited to discuss the outcome of the review, and if unable to attend, they receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirm they are invited to attend the care plan reviews and GP/NP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The unit coordinators interviewed gave examples of where a resident's condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the unit coordinators and registered nurses identifies that the service has access to a wide range of support either through the GP, NP, Mental Health of Older Persons Services, geriatrician and hospice staff.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>and protocols. Gloves, aprons, and goggles are available for staff. There are spills kits available.</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 holds a building warrant of fitness which expires 1 August 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs and is undertaken by a full-time and a part-time maintenance officer. The maintenance officer is available on-call out of hours and essential contractors are available 24-hours.</p> <p>Electrical equipment has been tested and tagged in January 2021. The hoist and scales are checked annually and are next due to be checked November 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range.</p> <p>Flooring is safe and appropriate for residential care. The facility has wide corridors with safety rails that facilitate safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and have attractive features, including raised, wheelchair friendly garden beds and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p> <p>The special care (dementia) unit has an internal paved courtyard with covered seating and raised beds. There is also a paved walking area from the unit's lounge to another garden and seating area. All the special care unit external areas are secure and appropriate for the level of care provided.</p> <p>Care staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving</p>	<p>FA</p>	<p>All residents' rooms in the rest home, hospital and serviced apartment areas have ensuites. The special care unit residents share communal toilet and shower facilities, of which there are sufficient numbers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares.</p> <p>Fixtures, fittings, floorings and wall coverings are good condition and are made from materials which</p>

assistance with personal hygiene requirements.		allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents can personalise their rooms (as sighted during audit) and the rooms are large enough for family and friends to socialise with the resident.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are dining rooms in each area. The dementia unit has a separate dining room and main lounge with a smaller seating area sensory lounge. There are family/whanau rooms in each area. There is a café in the atrium, a gymnasium and hairdressing salon.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is done on site. There are dedicated cleaning and laundry persons on duty each day. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety datasheets. Laundry staff label all resident personal items on admission and as required. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaners’ trolley sighted were labelled. The sluice rooms and the laundry are kept locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and cardiopulmonary resuscitation (CPR) are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The village has an approved fire evacuation plan. Fire drills occur six-monthly. The service has an emergency generator available, gas barbeques and cylinders, sufficient water (10 litres per resident for a minimum of three days) and food in the event of an emergency. Emergency lighting is in place. An electronic call-bell system was evident in all residents’ rooms and ensuites, communal toilets and communal lounge and

situations.		dining areas. The building is secure after hours. The dementia care unit has secure access.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All bedrooms and communal areas have plenty of natural sunlight and ventilation. General living areas and resident rooms are appropriately ventilated and heated with underfloor heating. Residents have panel heaters in their rooms that can be individually controlled via the thermostat. Heat pumps have been installed in communal areas. Staff and residents interviewed stated that this is effective. The entire site is smoke free.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager fulfils the role of infection control officer (ICO) and responsibility for infection control is described in the job description which was evidenced on the day of audit. The ICO oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by a Ryman head office and benchmarking occurs between Princess Alexandra and other group facilities. The head office infection control team are also available for direction and advice via email and telephone. Staff receive information and updated through the Chattr app. The ICO, clinical manager and unit coordinators meet regularly to discuss the programme as part of the infection control strategy.</p> <p>The facility has a COVID/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures and service readiness in addition to receiving extensive input and support from Ryman head office. Staff and residents have commenced Covid vaccinations.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the annual influenza vaccine. There has been one suspected outbreak in the previous year which proved to be a false alarm but was managed as genuine until proven otherwise in line with company policy.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	The Infection Prevention and Control committee meet monthly. The infection control officer has been in the role since January 2021 and completed an induction to the role and completed online 'bug control' training. The infection control officer in conjunction with the clinical manager collates infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections. The infection and prevention officer have access to an infection prevention and control nurse specialist from the DHB, infection control consultant, microbiologist, public health, GPs, local laboratory



infection control programme and meet the needs of the organisation.		and expertise from within the organisation.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection prevention and control policies that are current and reflect infection prevention and control standards, legislation and good practice. These policies are generic to Ryman and the templates were developed in association with an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</p>
<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 on the V-care system for all infections and are kept as part of the online resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the infection prevention and control meetings. Staff are informed of infection control through the variety of facility meetings and data is displayed in a visual format.</p> <p>The infection prevention and control programme links with the quality programme including internal</p>

		<p>audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, identify any areas for improvement and education needs within the facility.</p> <p>There has been one suspected outbreak in the May 2020 which was managed appropriately until negative results were received.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The facility has been restraint-free since March 2021. During the audit, there was one resident (hospital level) using an enabler (bedrails). This resident's file was reviewed. An enabler assessment was sighted. Voluntary consent was provided by the resident. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and management of challenging behaviours which includes assessing their understanding of restraint. Education for families on the risks of restraint have been undertaken which has contributed to the facility's recent restraint-free status.</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

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Robust systems are in place for the collection, analysis and evaluation of quality data. This range of data is collected across the service using VCare, an electronic data management system. Data is collated and analysed with comprehensive evaluation reports completed monthly and comparative reports six monthly. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other similar service types within Ryman facilities. Communication of results occurs across a range of meetings across the facility. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is collected around (but not limited to): falls, skin tears, pressure injuries and infections. Falls data for hospital level residents reflects low levels.	Falls data in the hospital continues to reflect monthly scores that are consistently below the Ryman benchmark of 9.2 falls per 1000 bed nights. The six-month average for Princess Alexandra (January 2020 – May 2021) indicates on average only 5.9 falls occur per 1000 bed/nights/month. Strategies implemented to achieve this positive outcome include the following: review, discuss and monitor falls fates weekly, monthly and six monthly to identify risk factors and trends; falls charts are displayed every month to heighten staff awareness; staff are completing ‘step back’ cards to reflect on and heighten their awareness of residents at risk of falling; hourly intentional rounding for identified high risk fallers and residents with vision impairment; carers handover to their buddy when they leave the floor; lounge carers remain in the lounge unless relieved by a caregiver or RN; residents are encouraged to attend the triple A exercise classes..

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>Ryman Princess Alexandra has introduced a number of initiatives to ensure residents nutritional needs are met and the dining experience improved. 'Project Delicious' has been implemented, commencing in March 2020 and results have been evaluated in the 2021 resident satisfaction survey.</p>	<p>All food is prepared, cooked and baking done on site. The four-week rotating seasonal menu and offers a variety of two mains, and two desert choices plus gluten free and vegetarian options. Kitchen equipment and tableware have been reviewed, and new purchases made to ensure timely delivery of meals at the desired temperature.</p> <p>Staff have received training in dining room etiquette and food presentation. Dining room settings have been reviewed to maximise socialisation among residents and linen tablecloths, flowers, linen napkins and background music (where appropriate) have been introduced to enhance the resident dining experience in all areas, including the hospital and special care unit to facilitate an ambience of relaxed dining as observed during mealtimes. Residents are provided with a menu whereby choices can be made in advance with the proviso that they can change their mind at any point should they prefer an alternative meal on the day. This was observed in the hospital dining room during audit.</p> <p>Evaluation of the project and dining experience has been measured by.</p> <ol style="list-style-type: none"> <li>1) Feedback from residents and families through monthly food surveys (10 residents per survey). The village manager dines with the residents on a weekly basis and the lead chef rotates through the different units, manning the servery to gain first-hand feedback from residents, families and staff.</li> <li>2) Ongoing education for staff around food services, dining room etiquette, nutrition and hydration.</li> <li>3) Resident surveys sighted evidenced residents and relatives are very satisfied with the meals and choices provided (an improvement from 4.11 to 4.46 in the latest resident survey).</li> <li>4) Interviews with residents and families on the day of audit all confirmed that the meals (choice, quality and presentation) were very good to excellent.</li> </ol>
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			The service has been successful in providing excellence in food services.
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>The facility has been restraint free since January 2021. One enabler is in place for a hospital level resident (bedrails). This enabler has been requested voluntarily by the resident and is being reassessed every six months. Monitoring of the bedrail is in place.</p>	<p>The facility is maintaining a restraint-free environment with restraint last used in January 2021. The hospital unit coordinator is the restraint coordinator and is responsible for leading this initiative. Strategies implemented include staff education on ways to maintain a restraint-free environment; and, explaining to staff the risks of restraint, what constitutes restraint, interventions, strategies, and accountabilities. Residents and families are well-informed at entry to the service regarding the care centre's goal of maintaining a restraint free environment and the benefits this has for their residents. Falls prevention strategies being implemented (link CI 1.2.3.6) assist in reducing the need for restraint.</p>

End of the report.