# Ranfurly Village Hospital Limited - Bob Reed, Ranfurly Care & Veterans

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Ranfurly Village Hospital Limited

**Premises audited:** Ranfurly Care and Veterans Facility

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 11 July 2016 End date: 12 July 2016

**Proposed changes to current services (if any):** This certification audit included an assessment of the service to provide medical services under their certification.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 59

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Ranfurly Village Hospital Ltd is privately owned. A general manager/registered nurse is employed and responsible for the daily operations of the service. A care manager and stable workforce support her. The service provides rest home and hospital level of care for up to 60 residents. On the day of the audit, there were 59 residents.

The residents and relatives spoke positively about the care provided at Ranfurly Village Hospital. The service has been assessed to be able to deliver medical services at the required standard.

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 resident and staff files, observations, and interviews with family, management, staff and the general practitioners.

Areas identified for improvement were around documented evidence of relative notification and documented interventions.

The service has been awarded a continuous improvement rating for excellence in food services.

## Consumer rights

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

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family stated they are kept well informed on their relative’s health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

## Organisational management

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| --- | --- | --- |
| 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. |

Ranfurly Village Hospital has implemented a quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety, including hazards. The health and safety, and infection control committee meeting includes discussion around quality data. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times. An implemented orientation programme provides new staff with relevant information for safe work practice. The education programme includes mandatory training requirements and additional in-service including medical conditions.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Onsite registered nurses oversee service delivery every day, in all areas. Each resident is comprehensively assessed. Care plans have been developed in consultation with the resident, family, general practitioner and other allied health professionals where appropriate. Residents care was evaluated at least six monthly. The general practitioners saw residents at least monthly.

A diversional therapist coordinates an activity programme that meets the recreational abilities and preferences of each resident group. There are individual and group activities planned to maximise the resident’s health and independence.

An electronic medicine management system of charting was being used by the service and was working well in practice. The medicine management system was managed appropriately in line with required guidelines and legislation.

The food service has been designed to provide residents with a restaurant style choice of food typically used in the hospitality industry. Residents chose their meals from a menu of choices that were displayed to them by staff, using electronic hand held devices. Residents and relatives interviewed spoke very highly of the presentation and choice of meals offered.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours. Electrical equipment is checked annually. All medical equipment and all hoists are serviced and calibrated annually. Hot water temperatures are monitored.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There are policies and procedures on safe restraint use and enablers. There were two residents voluntarily using enablers and three residents with restraints. A registered nurse/quality and risk coordinator is the restraint coordinator. Staff receive training around restraint and challenging behaviours.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator/registered nurse is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 47 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 1 | 98 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Nine residents (five rest home and four hospital level of care) and seven relatives (five of hospital level and two of rest home level of care) interviewed, confirmed that information has been provided around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Discussion with four healthcare assistants and three registered nurses (RN) identified they were aware of the Code and could describe the key principles of resident’s rights when delivering care. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The healthcare assistants interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.  Families and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  A multipurpose informed consent form is utilised by the service provider and is retained in each individual resident`s record reviewed. Additional forms, for example for annual influenza vaccinations were viewed in the eight resident files selected (five hospitals and three rest home). All resident’s files sampled had signed admission agreements.  The GP interviewed understood the obligations and legislative requirement to ensure competency of residents as required for advance directives and advance care planning. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance.  Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Returned service association welfare officers and the resident chaplain are available as advocates to residents/relatives. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal, email and written on the complaints form is maintained by the general manager using a complaints’ register. There have been 15 complaints to date for 2016. All complaints/concerns have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint, to the satisfaction of the complainant. Residents and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes.  Complaints forms and a suggestion box is in the main entrance. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service has available information on The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) at the main entrance to the facility. The code of rights is also displayed in the resident areas. A welcome information folder includes information about the code of rights. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission, with the general manager or care manager. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| 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 | The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. Staff attend privacy and dignity, and abuse and neglect in-service as part of their education plan. Care staff interviewed stated they promote independence with daily activities where appropriate. Resident’s cultural, social, religious and spiritual beliefs are identified on admission and they are included in the resident’s care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives. |
| 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 | There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. The Māori health plan identifies the importance of whānau. Assessments plans for Māori are completed and reviewed in the files of residents who identify with Māori. The general manager, care manager and care staff were able to describe how to access information and provide culturally safe care for Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six monthly to ensure the clients individual culture, values and beliefs are being met. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular onsite church services and they are supported to attend other community groups as desired. The service has a resident chaplain to provide church services and to visit individual residents as required. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process meets best practice in regards to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Healthcare assistants interviewed could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The management are committed to providing service of a high standard, based on the provider statement and philosophy. This was observed during the day with the staff demonstrating a caring and respectful attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Care staff and RNs have access to internal and external education opportunities. Staff have a sound understanding of principles of aged care and state that they feel supported by management. Regular facility and clinical meetings, and shift handovers enhance communication between the teams and provided consistency of care. The service employs a physiotherapist, and a physiotherapy aide for the mobility assessments of residents and provides safe manual-handling training for staff. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Management promote an open door policy. Relatives/residents are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings (open to family) and annual surveys. Results and areas for improvement are discussed at resident meetings (sighted in minutes) and posted on the resident noticeboard. Family meetings commenced in May 2016 and will be held three monthly.  Accident/incident forms for falls showed relatives had been informed of the incident. There were three reported incidents of pressure injury in June 2016. A shortfall was identified around documented evidence of relative notification for two pressure injuries. Relatives interviewed state they are notified promptly of any changes to resident’s health status.  Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ranfurly Village hospital Ltd is privately owned. The service has a working relationship with the veteran’s trust. Veterans are given priority for admission. The service provides rest home and hospital level of care for up to 60 residents. All beds are dual-purpose within a new purpose-built facility. There are 30 beds on level two, and 30 beds on level three. On the day of audit there were 21 rest home residents (eight on level two and 13 on level three) and 38 hospital residents (21 on level two and 17 on level three). There were two hospital level residents under 65 years of age with one under the younger person’s contract and the other under the long-term chronic health contract. All other residents were under the ARCC. The service was assessed as being able to provide medical services.  The general manager is a registered nurse (RN) with aged care management experience and has been in the role at Ranfurly for one year. She provides clinical governance on the board of trustees and reports to the village manager. The operations manager (non-clinical) supports the management team. An experienced care manager supports the general manager. A senior RN is the quality and risk coordinator.  The 2015 business continuity plan, quality plan and goals have been reviewed regularly to measure achievements and quality improvements. Ongoing goals are reflected in the 2016 quality plan. Goals for 2016 include obtaining the primary level of the ACC workplace safety management practice, complete construction of staff only area, further develop the outdoor areas to include a children’s playground and changing the kitchenette design to accommodate a baking area for residents.  The general manager maintains an annual practicing certificate and has maintained at least eight hours annually of professional development that is related to managing a rest home and hospital including attending aged care provider forum, first aid and human resource management. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During the temporary absence of the general manager the care manager provides clinical and management oversight of the facility including the on-call requirement. The RN/team leader is second in charge to provide cover for the nurse manager. A current practicing certificate for the general manager operations, nurse manager and RN/team leader were sighted. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that have been reviewed regularly by the service. Staff are required to sign the reading sheet to acknowledge they have read new/reviewed policies.  There are regular management, service and clinical meetings including infection control committee two monthly, health and safety committee two monthly and restraint meetings quarterly. Meeting minutes evidence discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audit and survey results. Trends are identified and analysed for areas of improvement. Healthcare assistants confirmed on interview they were kept informed on quality data including corrective actions and quality initiatives.  Internal audits are completed as scheduled. Corrective action plans are completed for any corrective actions required. The quality and risk coordinator signs off completed corrective actions and provides a monthly quality report to the general manager and facility meetings.  The service has a health and safety coordinator who has completed health and safety transition. The health and safety representative (interviewed) stated the health and safety committee of representatives across the services were involved in the development and review of health and safety goals. Staff are given the opportunity to provide input into the two monthly health and safety committee meetings. The health and safety committee review monthly accident/incident reports and review the hazard reports and register. Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case by case basis to minimise future falls. Health and safety information is displayed on the staff noticeboard. The representative interviewed (maintenance person) has been involved with the contractors regularly. The staff only area under construction is cordoned off safely and a hazard board was in place. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | As part of risk management and health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to the management, health and safety committee, clinical and facility meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.  Fifteen incident forms (three rest home and twelve hospital) were reviewed from June 2016. All incident forms identified timely RN assessment of the resident and corrective actions or recommendations that had been completed and signed off by the general manager/RN or care manager. Neurological observations had not been completed for unwitnessed falls (link 1.3.6.1) and any known head injury. Next of kin had been notified for all incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process.  The general manager could describe situations that would require reporting to relevant authorities. The service has reported two section 31 notifications (unstageable pressure injury and one fracture). The fracture was also reported to work safe. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Nine staff files were reviewed (clinical manager, two RNs, three healthcare assistants, one cleaner, one laundry person and one kitchen hand). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  The health and safety/educator (previous physiotherapist) is the facility Careerforce assessor for level three and four and provides staff training on safe manual handling. The education plan covers all the mandatory education requirements. Registered nurses have access to external training that includes clinical education relevant to medical conditions. In-service attended on-site delivered by external educators include end of life/palliative care, loss and grief, diabetes, pressure mapping and pressure injury prevention and management, wound care, and pain management and nutrition. Ten RNs are InterRAI competent. Staff complete competencies relevant to their roles. A number of staff have almost completed a communication course provided by an external agency. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager (RN) and the care manager/RN are on duty during the day Monday to Friday. Both share the on-call requirement for clinical and non-clinical concerns. There is a RN on duty on both levels on the morning and afternoon shifts. There is one RN on night duty to oversee the two levels. There are three HCAs on night duty.  Residents and relatives state there are adequate staff on duty at all times. Staff state they feel supported by the care manager and general manager who respond quickly to afterhours calls.  Activity hours were increased in August 2015 to provide activities over six days per week.  There are dedicated laundry and cleaning staff. The laundry hours have been changed in response to a shortage of linen available. The laundry now operates from 7am to 6pm with no further concerns around linen. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and resident register. Resident clinical and allied health records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements reflect all the contractual requirements. Residents and relatives reported that the general manager discussed the admission agreement with them in detail. All residents had the appropriate needs assessments prior to admission to the service. The RN ensures that residents are admitted to the service as per contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | A standard transfer notification form from the district health board is utilised when residents are transferred to the public hospital or to another service. The manager verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medicines management system was being managed appropriately in line with required guidelines, legislation and organisational policies. Electronic medicine charting was used for all residents. No errors in charting were detected in the sample of 16 electronic medicine records reviewed. All charts reviewed demonstrated that the general practitioner had reviewed the resident within the last three months. All medicines are dispensed to the facility by a contracted pharmacy. Unused medicines are returned to the dispensing pharmacy. The storage of medicine was secure. There was a system of medicine reconciliation in use for newly admitted residents. Two rest home residents were self-medicating at the time of audit. Both residents have self-medication competencies completed and reviewed by the GP. Registered nurses, who had been assessed annually as competent by other registered nurses, administer medicines. Registered nurses has completed syringe driver training and there is a close liaison with the hospice for advice and support for palliative care residents.  Medication fridge temperatures were being monitored daily and the temperature ranges were within accepted limits and actions taken if discrepancies were noted. General practitioners using the electronic charting system, were charting medicines correctly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | CI | The food service is based on the hospitality mode and has been designed to provide residents with a restaurant style choice of food. The catering manager in consultation with the dietitian has developed the menu. The menu for the day is pre-loaded onto electronic hand held devices. Nursing staff then used the hand held devices to display the proposed menu and pictures of the food to each resident. The staff worked with each resident to record their food choices for the day working within the resident’s ability to choose. Staff were aware of their food preferences and needs of those residents who could not indicate their own choices. Residents were able to build sub-choices within the range of their main meal choices (eg, they could make slight changes to sauces and build their own choice of desserts from the range of choices on offer). This information was then conveyed electronically to the chef and the pre-ordered meals were then prepared and delivered. Residents could change their choices as well. For some residents that are not able to choose, the families are involved in choosing the meals for their liking. The system has proved to be effective in meeting its aims. The catering manager was aware of all residents’ food preferences and special requirements and these preferences were recorded in the electronic system. The chef met weekly with the registered nurses to discuss residents of nutritional concern and the chef and nursing team then acted proactively to maximise the resident’s health. The catering manager checks with the residents personally if the food is to their expectations and discusses options with the residents when there are special requirements.  The weights of residents recorded in the clinical files reviewed demonstrated that this system was proactively achieving good results. The kitchen was well equipped. Food was appropriately managed in line with food safety guidelines. Pre-ordered food was delivered to resident areas in hot boxes, then decanted into bain-maries and served by staff according to resident choice.  Additional nutritious snacks were available for all residents.  The chefs were qualified and the kitchen staff had attended food safety education.  Residents and relatives interviewed spoke very highly of the food service likening it to a hotel service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is a documented policy on decline of entry to the service. When a potential resident’s entry to the service is declined, they are referred back to the referrer to ensure that they are admitted to the appropriate level of care provider. The general manager reported that the district health board needs assessors and social workers contact the manager to discuss the suitability of the potential resident prior to sending the family to view the facility. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The registered nurses utilise standardised risk assessment tools on admission and the InterRAI assessment tool. InterRAI assessments, assessment notes and summary were in place for all resident files reviewed. The long-term care plans in place reflected the outcome of the assessments. Cultural, sexuality and intimacy needs have been identified for the residents. Registered nurses are competent in the assessment of acute clinical needs of residents to be able to safely deliver care for residents under medical services. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans sampled were resident-focused and personalised. The care plans do not always describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process (link 1.3.6.1). There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview that they are involved in the care planning and review process. There was evidence of allied health care professionals involved in the care of the resident. Long-term care plans sampled were always reviewed and updated in a timely manner, following a decline in health. Short-term care plans were evident in the sampled files and developed following a change in health. Interventions documented were sufficiently detailed to address the desired outcome/goal. Integration of records and monitoring documents are well managed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents interviewed confirmed care delivery and support by staff is consistent with their expectations. Not all care plans documented interventions for all needs. Family confirmed they were kept informed of any changes to resident’s health status. Healthcare assistants interviewed state there is adequate equipment provided including continence and wound care supplies. On the day of the audit, supplies of these products were sighted.  There were nine wounds including one chronic wound and one pressure injury being treated at the time of the audit. Interventions for one chronic wound had not been documented in the long-term care plan. The registered nurses interviewed could describe the referral process to a stoma nurse specialist, continence nurse and mental health nurse. There had been no wound specialist input for two residents with wounds. Monitoring occurs for weight, observations, blood glucose and challenging behaviour. Observations after unwitnessed falls do not include neurological observations.  Healthcare assistants interviewed confirmed they are updated of any changes in resident’s care or treatment during handover sessions at the beginning of each shift. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a diversional therapist and an activities assistant to plan and coordinate the individual and group activities programme offered in all areas for six days per week. Care staff also participated in providing the individual and group activities programme. Residents had a written and implemented activities programme, which was evaluated and reviewed each time their long-term plan of care was reviewed. A weekly programme was displayed in large print in each area and staff were able to inform residents as to the programme and direct them to attend the activity of their choice. A daily record of each resident’s participation in group and individual activities was maintained. A wide range of activities was included in the programmes. The group programme included external outings.  Residents and relatives interviewed spoke highly of the activities programme. The programme was operating in all areas during the audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Registered nurses completed a review of all resident’s initial care plans within three weeks of their admission and updated each resident’s plan of care as necessary. Registered nurses had a system in place which ensures that each resident was formally reviewed six monthly by all members of the multidisciplinary team and a record of the review was documented. Families were invited to contribute their opinions and attend the reviews where possible. Following the review, the resident’s long-term care plan was amended to reflect any changes. When clinically indicated, care plans were evaluated and reviewed more frequently. |
| 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. | FA | There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. The residents and the families are kept informed of the referrals made by the service. The registered nurses facilitate internal referrals. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | All chemicals were securely stored. Storage areas were locked. Chemicals were clearly labelled and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they could access personal protective clothing and equipment at any time. As observed during the audit staff were wearing gloves, aprons and hats when required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 3 October 2016. The facility has three levels (ground – staff service area only, second floor - reception and 30 dual-purpose beds and third level – 30 dual-purpose beds) with lift and stair access between the levels.  The service employs a full-time maintenance person that covers maintenance for the hospital and village. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24-hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical equipment (including beds, hoists and weigh scales).  Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were maintained below 45 degrees Celsius. A staff only area is under construction on the ground floor. This area was cordoned off safely and a hazard board in place. The maintenance person (also a health and safety representative) meets with the contractors regularly.  The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids.  There is safe access to the outdoor areas where seating and shade is provided. There are further plans for 2016 to develop the grounds by adding areas that can be utilised by resident’s family and children such as a child’s playground.  The healthcare assistants and RNs interviewed stated they have sufficient equipment to deliver the cares safely, as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are sufficient numbers of toilets and bathrooms for the number of residents at Ranfurly. Privacy is maximised as the rooms have ensuites. All bathrooms and toilets are maintained to a good standard, and are disability accessible with easy to clean walls and floors. |
| 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 adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. The rooms are well equipped with appropriate furniture and mobility equipment as required. Residents have personalised their rooms. |
| 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 | Ranfurly has two designated levels for residents. Each level has a large, well-lit dining area and lounge rooms. There is a diversional therapy room where supervised activities take place.  Residents are able to move freely and furniture well arranged to facilitate this. The service has a physiotherapy room and the physiotherapist and the physiotherapy assistant are utilising it well. |
| 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 | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff seven days a week. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.  The laundry has an entry and exit door with defined clean/dirty areas within the laundry. Staff were observed to be wearing correct personal protective equipment when sorting dirty laundry. Safety datasheets for chemicals were readily accessible. Chemicals are stored appropriately at all times. The cleaning trolleys were well-equipped and locked in designated areas when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies (torches/batteries) are readily available on each floor with civil defence equipment readily available. There is 4,000 litres of water in tanks with a gravity feed tap in the event of no power. There is at least three days of food stored on-site with barbeques and gas bottles for alternative cooking. The emergency lighting is LED with eight hours of light. There is an agreement with an external contractor for the supply of a generator in the event of an emergency.  The fire evacuation scheme was approved by the fire service 25 October 2013. The maintenance person is the fire warden responsible for staff orientation and ongoing education in fire and emergency procedures. Six monthly fire drills are completed. There is a first aider on duty at all times.  Resident’s rooms, communal bathrooms and living areas all have call bells linked to pagers worn by staff. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. Night porters employed by the village, conduct security patrols from 6pm to 6am seven days a week. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There is adequate light and ventilation in all bedrooms and communal areas. The facility is a new build and is very well presented. Residents and families interviewed confirmed the environment is warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control coordinator is a registered nurse who has been at the service for four years and in the role for the last year. The infection control coordinator oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the infection control committee and management team.  The 2015 infection control programme has been reviewed and is linked to the quality system.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The RN infection control coordinator has attended external infection control and prevention control education in 2015 and 2016. The infection control committee consists of an infection control representative from each service area. The committee meets two monthly. The meeting agenda includes developing and reviewing the infection control quality goals.  The infection control coordinators have access to GPs, local laboratory, the infection control nurse specialist and public health departments at the local DHB for advice and an external infection control consultant specialist. |
| Standard 3.3: Policies and procedures  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. | FA | The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and are reviewed regularly, last April 2016. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and are ongoing six monthly.  Resident education is expected to occur as part of providing daily cares as appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed on the staff infection control board in the staff office. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the infection control committee meetings and clinical meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit, there were two residents with enablers and three residents with restraints. Two of two resident files reviewed for enabler use identified the resident had given voluntary consent. Restraint and challenging behaviour education is included in the training programme. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A registered nurse (also the quality and risk coordinator) is the restraint coordinator with a defined job description. The restraint group meet three monthly to review enabler use. Care staff receive education on safe restraint use at orientation and ongoing. There is ongoing education including challenging behaviours. Staff complete restraint competencies. Quality and clinical meetings include discussion on restraint. Staff carry out and record restraint monitoring including cares delivered during the restraint period. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, approval group, resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form was completed for the three residents requiring restraint (sighted). Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluations occur three monthly as part of the ongoing review for residents on the restraint register, and as part of their care plan review. Families and the GP are included as part of this review where possible. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage is monitored regularly. The review of restraint use is discussed at the approval group meetings and relevant facility meetings. The facility is proactive in minimising restraint. There is a replacement programme in place to replace the existing beds with wider beds to prevent residents from rolling out of bed and reduce the need for restraint. Perimeter mattresses are also used. Internal restraint audits are completed. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | All accidents/incidents are reported on the required reporting form. Accident/incident reporting forms reviewed for falls, bruises, skin tears evidenced the relatives had been notified of the incident. There were three reports of pressure injuries for the month of June. There was documented evidence of relative notification for one pressure injury. | There was no documented evidence of relative notification for two pressure injuries in the month of June 2016. | Ensure there is documented evidence of relative notification for all incidents.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Following a decline in health, long-term care plans were reviewed and updated in a timely manner. Short-term care plans were evident in the sampled files for short-term needs and regularly evaluated. Short-term care plans were completed for seven wounds. One of two chronic wounds (pressure injury) was included in the long-term care plan and the wound nurse specialist had reviewed another. Seven of eight long-term care plans had documented interventions and management for medical conditions. All witnessed and unwitnessed falls were reported and documented in progress notes. There were no neurological observations for three resident unwitnessed falls. | (i) One of two chronic wounds did not have interventions documented in the long-term care plan. (ii) One long-term care plan did not have specific interventions documented around epilepsy management. (iii) One long-term deteriorating wound has not had external specialist input. (iv) Neurological observations had not been completed for three residents who had unwitnessed falls, as required by company protocol. One fall resulted in a bruise to the head. | (i) Ensure that the long-term care plans have documented interventions for chronic wounds. (ii) Ensure long-term care plans include specific interventions and management for medical conditions. (iii) Ensure that chronic wounds are referred to a wound nurse specialist and interventions are documented. (iv) Ensure neurological observations are completed for all unwitnessed falls.  90 days |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | The service has exceeded industry standards in meal choice, presentation, choice and technology used to ensure its resident’s dietary preferences are met. Residents choose their meals from a menu of choices that were displayed to them by staff using electronic hand held devices. This information was then conveyed electronically to the catering manager and the pre-ordered meals were then prepared and delivered. Residents and relatives interviewed spoke very highly of the food service and catering team. Ranfurly was the winner of an excellence in care awards at the 2014 New Zealand Aged Care Association and went on to win the supreme award. | The catering manager has continued to implement quality improvements to the menu including an Asian menu, specific vegetarian menu and improved presentation of pureed/moulied meals. The current dinner service provides a choice of two meals. Residents are able to build sub-choices within the range of their main meal choices (eg, they could make slight changes to sauces and build their own choice of desserts from the range of choices on offer). Residents could also change their choices. For some residents that are not able to choose, the families are involved in choosing the meals of their liking. The weights of residents recorded in the clinical files reviewed demonstrated that this system was proactively achieving good results. The system has proved to be effective in meeting its goals around meal choice and satisfaction. Before and after photos of meal servings demonstrated a marked improvement in meal presentation. The catering manager has been invited to present his catering skills and meal preparation at a dietitian seminar. The resident survey in 2014 was 65% meal satisfaction and in 2015, 79%. Resident meeting minutes evidenced discussion and satisfaction around meals. |

End of the report.