

# Rannerdale War Veterans Home Limited

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Rannerdale War Veterans Home Limited
<b>Premises audited:</b>	Rannerdale War Veterans' Hospital and Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 19 November 2014    End date: 19 November 2014
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46

# 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

Rannerdale War Veterans Home Ltd is situated in Riccarton Christchurch and provides residential care for up to 61 residents who require hospital and rest home level care and for younger people with a disability. Occupancy on the day of the audit was 46 residents; 18 receiving hospital level care; 27 rest home care and one younger person with a disability. The facility is owned by The Rannerdale Trust.

Six of the previous seven required improvements have been addressed. Areas outstanding and new areas identified as a result of this audit relate to: privacy in bedrooms; staff training, competencies, job descriptions and performance appraisals; timely provision of services when the condition of a resident changes; review and evaluation of care plans; issues identified related to administration, storage of controlled and other medications and aspects of the medicine records; evidence of a current review of the menu; and cleanliness of the kitchen and storage of food items.

## 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.
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The privacy issue raised at the previous audit relating to service delivery being carried out in the communal lounge has been addressed; however, another privacy issue is identified for improvement relating to the small windows in residents' bedroom doors.

Residents and family report that staff communicate in an effective manner and there is evidence that open disclosure occurs.

There is a detailed complaints register as part of the facility's complaints process. Those complaints reviewed have been documented with actions completed; all reviewed have been resolved.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The vision, goals and scope of the organisation are on display at the main entrance and integrated into the current strategic plan for the facility. The vision and core values are reviewed annually by the chair of the board. There is a management team, which meet monthly. A quality and risk management system is well documented. Incidents, restraint, health and safety, infection control,

internal audits, family surveys and complaints feedback are all part of the quality improvement processes and are agenda items at the monthly quality improvement meetings.

There are appropriate risk ratings identified to ensure adequate controls are in place, addressing an issue identified at the previous audit.

Review of staff records provide evidence that human resources processes are followed as required (e.g., police vetting, reference checks, and performance appraisals), meeting a previous required improvement; however, staff job descriptions and individual employment agreements are not consistently seen in all files and this needs addressing.

A detailed induction and orientation is in place for all staff. There is evidence indicating an in-service education programme is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to the care of older people. The organisation now keeps a copy of honorary staff registration meeting a previous required improvement.

An area identified for improvement is for the clinical nurse manager to have a job description and an annual performance appraisal. Staff first aid training and competencies are not available as they are kept off sight and this also needs addressing.

Staff rosters show there are adequate staff with the relevant experience and skills to cover all shifts.

## 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 medium or high risk and/or unattained and of low risk.
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Admission agreements are being completed within the required contractual timeframes, which addresses a previous required improvement.

The electronic interRAI programme is being used to help with the assessment of all residents and information obtained through this process is contributing to care plans. This now includes clinical information, which addresses a previous required improvement. Registered nurses provide supervision to the trained caregivers who provide most of the care and support to residents according to the care plans.

All residents have comprehensive care plans and service delivery plans. Positive feedback about the quality of care being provided is reported, although the need for all residents to receive their care within a safe and timely manner is an area requiring improvement. There is evidence that care plans are being reviewed every six months and as needed; however, there is a lack of detail about the level of achievement of goals, which needs to be addressed. The need for short term care plans to show review processes also requires improvement.

This service is moving to a rehabilitation and restorative model, which through the planning, delivery and review of individualised and group activity and physical therapy programmes is being implemented at a level of continuous improvement. The required improvement about ensuring residents' activity plans reflect their interests has been addressed.

Medicines are mostly being managed according to the policy and procedure documents with some shortcomings around the retention of stock, the use of faxed records, non-recording of allergy status, recording of sample signatures and the management of loose medicines.

Only favourable feedback about the meals is provided. A four weekly rotating menu with winter and summer variations is in place, although evidence of its review by a nutrition professional is not available during the audit. To ensure food and hygiene safety are maintained there are required improvements around food storage, which was also an issue at the last audit, food and rubbish disposal, and the cleanliness of the kitchen and food service area.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There have been no building alterations since the previous audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. The service does not currently use any restraints, and one resident has an enabler in place which is monitored and reviewed according to the organisation's processes.

## 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 facility's clinical nurse manager collects monthly surveillance data and reports to the monthly quality improvement meeting. Infections are analysed and trends identified and processes put in place to minimise infections.

## 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	11	0	3	3	0	0
Criteria	1	36	0	4	3	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Systems are in place to ensure residents are advised on entry to the facility of the complaint processes. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents interviewed demonstrate an understanding and awareness of these processes.</p> <p>The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility and there are seven complaints recorded in the last year. A review of three recent complaints verified these have been resolved in a timely manner and meet the requirements of right 10 of the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>PA Low</p>	<p>Residents and family members interviewed, and observation on the day of the audit confirms Rannerdale staff respect residents' personal privacy in the communal areas, addressing a previous area requiring improvement. However, there are eight bedroom doors that have small round windows installed, with no method to ensure the privacy of the resident in the bedroom and this requires improvement.</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>An Open Disclosure Policy is sighted. The policy advocates that disclosure to the resident should generally be made when an adverse resident event has occurred. Typically disclosure should be within 24 hours of the event depending on the specific circumstances of the event. An incident report relating to a skin tear is reviewed and verifies the facility has notified the resident's family within 24 hours of the incident, the treatment provided and a follow-up of when the resident was seen by the GP. This is also verified in the progress notes in the resident's hardcopy records.</p> <p>Interpreter and Translation Services are available should these services be needed. A policy document provides contact details for services. The policy also states those residents with hearing and visual deficits are accorded the degree of explanation or repetition necessary to establish recognition. Staff name badges are in large print for easier identification.</p> <p>The Code of Rights pamphlet provided to residents on admission, displayed on walls, and available at the facility entrance, confirms the residents' right to effective communication. There is evidence in residents' files and during interview that the facility communicates effectively with residents and their families at all times. They report that they are kept informed on issues relating to their family member and staff are always willing to help.</p> <p>Staff are observed explaining and giving information to residents. Residents' meetings are held regularly to enable residents to be informed, ask questions and discuss issues. The minutes of these are documented and detailed, as sighted.</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>The facility is owned by the Rannerdale Trust, consisting of 10 members on the board of directors, six who are operational in the facility. The general manager (GM) and finance manager of Rannerdale War Veterans Home Limited sit on the board and oversee the day to day running of the facility and report to the board every month. The facility has a strategic business plan which is under draft at the time of audit; this is identified in the latest board minutes, signed by the chair.</p> <p>The vision and goals of the organisation are on display at the main entrance and integrated into the current strategic plan and goals for the facility. The vision and core values are reviewed by the chair of the board annually. There is a management team for the facility that also meets monthly, overseen by the GM, and includes the operations manager (OM), the clinical nurse manager (CNM), the finance manager (FM) and an external projects manager who sits outside the management team, but</p>

		<p>reports at these meetings (minutes sighted). A suite of policy and procedure documents is sighted with the focus on quality aged care provision. The quality management function includes a 'Strength, Weakness, Opportunity and Threats' (SWOT) analyses that occurs prior to the development of the strategic plan, and this is currently occurring with input from the external projects manager; purpose, values, scope and direction are included.</p> <p>The CNM (interviewed) has been in her position for six years, and has on-going professional development with a focus on clinical issues. The OM has been at the service for 10 plus years and is interviewed during the audit as the GM, with over five years' experience in the position is not available. There are suitably qualified people to relieve when managers are on leave or away from the facility.</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>There is a detailed quality and risk management plan which is reviewed annually (last reviewed in April 2014). The organisation's quality policy and risk management plan details the responsibilities for quality and the responsibilities for each manager. The GM, OM (interviewed) and CNM (interviewed) run the quality improvement programme and discuss quality initiatives and indicator feedback at the monthly quality meetings (minutes sighted). Feedback from residents, family and staff is sought regularly throughout the year including as formalised resident and family surveys (sighted).</p> <p>A document control system is in place to manage all documents, policies and procedures and these are reviewed at least every two years. Obsolete documents are archived electronically and paper copies removed from circulation.</p> <p>A range of quality indicators have been monitored throughout 2014. These include a comprehensive range of both clinical and non-clinical indicators. The quality and risk management plan reviewed includes all aspects relating to the facility (e.g., governance, finance and business, quality and risk activities such as complaints, incidents and accidents, residents' rights, human resources, provision of direct care, infection control, food and nutrition, laundry, cleaning, health and safety, emergency, security and environment). There are key performance indicators identified for each area. The results of audits are detailed in written text and graphs, with analyses of results.</p> <p>A risk management register is sighted and includes the type of any risk, description, treatment, control, monitoring, and review time related to each risk area depending on the level of the risk, addressing a previous required improvement. The OM</p>

		<p>reports that the register is updated at the end of each month following analyses of data and the quality meeting.</p> <p>If there are areas requiring improvement a corrective action plan is put in place. An example sighted is the CNM identified during a medication chart audit that the allergies box is not always ticked on the medication prescribing form. A corrective action process includes discussion with the general practitioners (GP) and a review is planned to occur later in November.</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>	<p>FA</p>	<p>Within the quality management system is the system for documenting, reporting and investigating adverse events. There are a range of documents (policies, procedures and guidelines) to assist staff in investigating incidents and accidents and taking appropriate action. There are also forms specific for reporting by staff, to the CNM or OM.</p> <p>There is a monthly analysis of incident and accident reports and individual events are to be followed up by the registered nurse on duty each shift. The CNM is responsible for collecting forms, and she reports she then discusses the content with the OM. Collated data is then analysed to identify any trends as part of the quality meeting. Quality minutes reviewed verifies this discussion and reporting.</p> <p>Adverse events reported includes a range of incidents and accidents, including falls, skin tears and bruises, a range of infections (e.g., skin, respiratory, urinary tract infections (UTIs), incidents and accidents, near misses, serious and sentinel events). Non-clinical indicators include complaints, staff injuries and accidents, staff training opportunities, property, security or emergency incidents. In the infection control suite of policies there is a notifiable diseases policy which describes those diseases which are notifiable and the process to be followed for reporting them. The OM and the CNM are familiar with essential notifications they must report to other authorities.</p> <p>Three completed incident forms are reviewed and all required actions are taken including notification of families, GPs, pharmacy as appropriate. All relevant corrective actions raised are communicated to staff in staff meetings (minutes sighted), reviewed, progress tracked and preventative measures implemented.</p> <p>Incident reports are sighted and include discussion with family, as appropriate. A monthly tally of incidents is documented and if there are identified trends, for example someone who may be a 'frequent faller', the physiotherapist will be informed. Records of this are sighted.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are policies and procedures covering all aspects relating to staff recruitment, induction and orientation, performance appraisals, training and competencies. There is a policy on police vetting which states that all new staff will have a police check prior to commencement of employment. Staff members working within a professional scope of practice have their qualifications verified (sighted) to ensure there are no restrictions on their scope of practice.</p> <p>All recruitment is currently managed by the GM or OM, with support from the CNM for all clinical appointments. The OM reports that when a vacancy occurs, the GM manages the initial advertising then the responsibility for shortlisting, interview, reference checks and police checks is done by the OM.</p> <p>Competency checks are completed prior to any appointments by the CNM. Professional qualifications are verified and filed. Other professionals who are independent of the facility also have relevant checks completed (sighted), addressing a previous required improvement. All APCs are current and securely filed. The GP's relevant qualifications are sighted.</p> <p>Staff files reviewed have documentation including police checks, reference checks, curriculum vitae (CVs), and orientation sheets, however job descriptions, employment agreements, competencies and first aid training, the CNM's job description and performance appraisal are not included and this requires improvement. Also included in files are training certificates for individual staff. Cleaning and laundry staff now have completed performance appraisals and this previous required improvement has now been addressed.</p> <p>All new staff receive a comprehensive orientation. For caregivers an initial session is held with the CNM who takes responsibility for all training. This covers the introduction to the facility and the policies. New staff are also given an orientation pack. This has a checklist of all activity required to be completed by the person and is expected to be completed in a timely way, within three months. New staff are then paired up with a more experienced staff member for at least two days of duties. A review is completed, and then as they are able to perform required duties, they are given more responsibility. All staff interviewed confirm the orientation was completed and they felt competent to carry out their duties as required.</p> <p>A comprehensive annual training programme is in place. The folder sighted includes the sessions, content and the number of staff who have attended. There are self-directed learning packs for staff that miss the regular fire drills. There are a number</p>

		<p>of modules that are compulsory for all staff and this includes training about the Code, infection prevention and control, manual handling, challenging behaviour, complaints and informed consent. All care staff must complete Aged Care Education (ACE) training and the CNM is a qualified assessor and manages this programme. Of the files reviewed all staff have been trained on this level.</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>	FA	<p>There is a policy document in the HR policies sighted that guides staff hours and roster, and staff skill mix. This describes the process for developing rosters, staff designations and hours that are set according to the needs of the residents, individuals and occupancy numbers. This will take into consideration the age, gender, safety, response times, ethnic requirements, cultural mix and equipment availability (i.e., hoists and hydraulic beds). Staff hours are to be set to ensure that they are sufficient to provide safe care in a timely manner. This takes into account the dependency levels (NASC Assessments), time required to provide care according to the individual's care plans.</p> <p>All rosters are maintained by the CNM and are prepared in advance using the organisational tool. The tool is able to ensure safe staffing levels as levels of need change.</p> <p>The rosters are sighted for the current week of the audit and these confirm adequate cover for the acuity needs of the current residents. The CNM reports any absences are able to be covered internally as there is a number of 'casuals' able to be called on.</p> <p>Staff, residents and family members report there are sufficient staff on all shifts.</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>A spreadsheet with the names of all residents on it is sighted and notes the date of signing of admission agreements. All residents except one, who have been admitted since the certification audit, have signed their admission agreement within the required timeframe of ten days. The exception is for a resident in the process of transferring from respite to long term care and therefore signing of the agreement has been delayed. As admission agreements are being completed within the required timeframe, as noted in the Aged Related Residential Care (ARRC) agreement, the required improvement from the certification audit has been addressed.</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>PA Moderate</p>	<p>Policies and procedures on medicine management provide staff with clear guidelines and describe key responsibilities. Medicines are being prescribed, dated and signed in the respective sections of the medicine charts and all are stored in a locked area. There is evidence of the date and signing of discontinued medicines. The pharmacy delivers the medicines and these are checked and signed in by the registered nurse on evening shift and again by the night nurse, when they are checked against individual medicine charts. Records of these checks are on a clipboard and are sighted with different ones available for new and/or short term medicines. Medicine administration record charts are being signed in a consistent manner, and medicines are being reviewed on a three monthly and as needed basis. There are two sample signature systems in place for staff involved in medicine management and there is a need to standardise this process. It is observed that staff are administering off faxed medicine records for more than 48 hours and this too needs to be addressed.</p> <p>Controlled medicines are being managed according to documented procedures, with relevant weekly and three monthly checks being made; however expired drugs have not yet been returned to the pharmacy.</p> <p>A mid-day medicine round in a hospital wing is observed and accepted medicine administration practise is evident, except for an antibiotic that has been previously separated from the card, plus an unnamed cytotoxic medicine that is reportedly for the evening round, being taped to the side of the medicine trolley. Such a practise requires improvement.</p> <p>Staff report that all staff responsible for medicine administration have a current competency and are able to describe the process. Like other staff training records, records of these are unavailable on the day of audit; therefore this shortcoming is included in the required improvement on the unavailability of staff training records, which has been raised in a different section (refer standard 1.2.7) of this report.</p> <p>The registered nurse reports that resident self-medicating is supported. A description of the process is consistent with expectations.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional</p>	<p>PA Moderate</p>	<p>Residents express satisfaction with the meals and the key message is that there is no reason for complaint about the food provided. Meals are provided according to personal profiles obtained on admission. These are in personal files and a copy is provided to the kitchen. Personal references, food intolerances and information</p>

<p>needs are met where this service is a component of service delivery.</p>		<p>about hot drinks and breakfasts are all described. Main meals are cooked according to a four weekly rotating menu, which has summer and winter variations. The cook informs this menu has been reviewed by a dietitian, however there is no documentation confirming this and this needs to be made available.</p> <p>Nursing staff describe the processes around the assessment of dietary needs, there is evidence a dietitian is consulted when required and that personal weights are monitored on a monthly basis. Detailed lists of food preferences and individual dietary needs are used by the cook and kitchen staff to ensure residents have additional nutritional requirements met or special diets provided when these are indicated.</p> <p>An external catering company manages the kitchen at the Rannerdale Home. Food items are ordered and purchased by the main cook and delivered into the facility for on-site preparation, cooking and serving. Records of fridge and freezer temperatures and of hot food are being maintained on a daily basis and these are sighted, however there are no other copies of internal audits available on the day of audit. There are some areas of food storage and disposal and aspects of the lack of cleanliness in the kitchen that require improvement as they pose a risk to food safety.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>As identified in criterion 1.3.3.3 there are examples of residents with additional care needs, or who may experience a new problem, not having received the level of care and support they require.</p> <p>Otherwise the residents' assessed needs and desired outcomes are being addressed according to their assessed needs. There is evidence that care plans respond to the identified needs and preferred outcomes (of residents and families) resulting from the assessment process. InterRAI is used to assist with the assessment process and identify priorities. Care plans guide the support and interventions being provided and this is noted by care staff. It is also evident that once a need has been brought to the attention to a suitably qualified staff person, or a referral to an appropriate service has been made, then every effort is made by staff to ensure their instructions are carried out accordingly. Residents and family members interviewed are satisfied with the services provided and none of those interviewed have any complaint.</p>

<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>Residents have a goal that relates to activities on their individual care plan, they have a personal profile that includes historical and family information and identifies personal preferences and there are separate activity and physical therapy related goals. Intervention plans relate to the personalised goals. There is good evidence in documentation sighted and in information obtained during resident and staff interviews, that personal preferences are being reflected. The issue raised at the certification audit has been addressed.</p> <p>Rannerdale is in the process of changing the focus of their service delivery to a rehabilitation and restorative model. The area where progress of this change is most evident is in the activity area, which is now showing evidence of continuous improvement. The number of staff involved is credible with two qualified occupational therapists and a qualified physiotherapist in the team. A physiotherapy assistant is increasing hours, which are planned to go up to 20 per week.</p> <p>During interviews, residents volunteered information about how much they like the exercises and sessions such as hand therapy, how they do not like to miss them, that they find they are feeling better from them, they now have movement they did not previously have and how good the staff are about helping them with the exercises. They also report that they can participate in a range of activities and that they can choose the ones they want to follow through with. They note that one to one time may also be provided and this may occur with an activity staff person or a caregiver.</p> <p>An activity plan for the month of November is sighted and shows that a holistic (e.g., physical, cognitive, social, spiritual and sensory) range of options are included and that more than one option may be available at a specific time.</p> <p>All individual activity goals and plans of residents are being redeveloped following functional assessments and progress with these is being reviewed. Rehabilitation team meetings and meetings with clinical staff are ensuring the programme and changes are also being reviewed and evaluated. Referrals for specific issues such as those identified as a falls risk are being made and processed.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Staff provide examples of adaptations they have made for residents when their condition has changed. Progress notes also include records of changes of care occurring for residents as a result of long and/or short term changes in identified needs.</p>

		<p>Residents interviewed state they are involved in the care plan section of their service delivery plans and that when things change for them the care provided is changed accordingly.</p> <p>All residents' records sighted for people who have been in the facility for more than three months show that the service delivery plans are being reviewed every three months. Comprehensive reviews are being maintained in the activities and physical therapy sections of residents' records. However, care plan reviews mostly state 'No change' and a required improvement is that these reviews are consumer focused and indicate the degree of achievement, or response to the support/interventions. In the few files where reviews note a difference, there is evidence of changes being made to the goal(s) and/or the intervention(s) in the care plan section of the service delivery plan.</p> <p>Short term care plans are being used for short term problems such as infections and skin tears. Wound care plans are also in use. Wound care plans show ongoing review, however short term care plans are not showing evidence of ongoing review or evaluation until their resolution, which may be several weeks later. This is also an area requiring improvement.</p> <p>The areas requiring improvement in this standard are consistent with the findings in criterion 1.3.3.3 where the lack of effective monitoring is contributing to shortcomings in service delivery.</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 warrant of fitness (WOF) is sighted and expires on 1 January 2015. There have been no changes to the building since the previous audit.</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>	<p>FA</p>	<p>Residents' records and staff interviews reveal examples of delays in the reporting and interventions for suspected infections during service delivery. This is raised as part of the improvement required in standard 1.3.3 regarding the need for ongoing monitoring and for early interventions. However, the system for the surveillance of infections is being implemented according to requirements.</p> <p>A form sighted for the purpose of collecting monthly data on all infections is maintained by the RN in the facility's office. The CNM collects the monthly report sheets and the information is collated listing specific infections of urinary tract, skin</p>

		<p>and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections. This gives an up to date analyses of trends and patterns.</p> <p>Documentation sighted includes the collection, collation and analysis of information on infections and the measurement of incidence and recommendations for minimising infections. A recent example of identifying trends in October showed a spike in ear infections has been noted and very quickly analyses identified the reason which is now being addressed.</p> <p>Evidence in the last two quality improvement meeting minutes and staff meeting minutes verify that IC surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the organisation.</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>The facility has policies, procedures and forms in relation to the use of restraints and enablers. There is a definition of restraint and enabler which is consistent with the standards. There is a flow chart to guide the decision making before any restraint is considered and a consent process for residents and family or enduring power of attorney (EPOA). There are forms for consent, application, approval group recommendations, monitoring and review.</p> <p>The CNM is the restraint coordinator and the restraint approval group is part of the quality improvement committee. The approval group must approve the use of any restraint for a resident before it is utilised with that person.</p> <p>The facility has a philosophy of no restraints in use. There is one enabler being used at the time of the audit. Regular monitoring is undertaken and records of this are sighted as being completed as required.</p> <p>There is a restraint register which is current with the one current enabler which is bedrails for safety reasons. This includes a 'key' for the purpose of the enabler; whether the person is at risk of falls, a risk to themselves or a risk to others.</p> <p>Education is provided to all staff as a compulsory module at orientation and includes reading the restraint and enabler policies and procedures. In-service education is part of the annual training schedule.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	Residents and family members confirm that resident’s privacy is respected in all communal areas; however, there are eight bedroom doors that have a small round window installed in the door, approximately 20 centimetres in diameter, with no method to ensure the privacy of the resident in the bedroom.	Eight bedroom doors have a small round window installed in the door, approximately 20 centimetres in diameter, with no method to ensure the privacy of the resident in the bedroom.	<p>The service respects the visual privacy of the resident.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The facility has a detailed training programme that includes formalised New Zealand Qualifications Authority (NZQA) modules, in-service education and competency assessments. There is a planned performance appraisal process; however the CNM’s performance appraisal or job description is not included in her file.	First aid training and staff competencies are not able to be reviewed as the training co-ordinator has these off site. Staff job descriptions and individual employment agreements are not sighted in seven staff files reviewed. The CNM does not have a performance appraisal or a job	<p>There is evidence of staff training, competencies and position descriptions in staff files reviewed.</p> <p>180 days</p>

		First aid training and staff competencies are not able to be reviewed as the training co-ordinator has these off site. Staff job descriptions and individual employment agreements are not sighted in seven staff files reviewed.	description for her position.	
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>Appropriate prescribing and dispensing of medicines are in place, reconciliation of medicines is occurring in an accountable manner and reviews are occurring three monthly and as needed. Areas around storage, administration and aspects of the medicine records require improvement.</p> <p>Not all residents' medicine records have the allergy status recorded. Two medicines (an antibiotic and a plastic bag of cytotoxic medicines for evening administration) are taped to the medicine trolley. Not all medicine records have sample signatures on them and faxed medicine administration records are being used beyond 48 hours.</p>	<p>The medicines management system has areas that do not comply with accepted protocol and guidelines. These include return of drugs to the pharmacy, allergy status is not on all medicine records, two medicines (an antibiotic and a plastic bag of cytotoxic medicines for evening administration) are taped to the medicine trolley, not all medicine records have sample signatures on them and faxed medicine administration records are being used beyond 48 hours.</p>	<p>All aspects of the medicine management system are to comply with accepted legislation, protocols and guidelines.</p> <p>90 days</p>
<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>	PA Low	<p>A four weekly rotating menu with winter and summer variations is in use and the cook uses this to guide meal preparation. It is reported that the menu is supplied by the contractor that is responsible for overall management of the food provision and kitchen. There is no evidence available on the day of audit that the menu has been reviewed</p>	<p>Reports that the menu has been reviewed by a dietitian, or other suitably qualified professional, are not able to be validated on the day of audit, as supporting documentation is not available.</p>	<p>Evidence is required that a suitably qualified professional confirms the menu in use meets recognised nutritional guidelines appropriate to the consumer group.</p>

		by a suitably qualified professional, although kitchen staff report this has occurred.		180 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>An external contractor is responsible for the overall management of the kitchen although direct responsibility for the kitchen is delegated to the kitchen staff within the facility. There are a number of practises observed and reported that are not meeting food safety and kitchen hygiene requirements. Examples of these are as follows:</p> <ul style="list-style-type: none"> <li>• Food items stored in the fridge have a day sticker with a date on them and although staff inform they are not used beyond a 24 hour timeframe, a number of foods such as jellies and condensed milk are dated back a week (and more) and have not been discarded.</li> <li>• Leftovers, which include cooked meat, are disposed of into a pig bin for delivery to a pig farm, and there is no certification that it is heated appropriately.</li> <li>• Rubbish bins outside the kitchen are overflowing.</li> <li>• Foods are stored on the floor of a pantry and of a walk-in cooler, rather than just on shelves.</li> <li>• Decanted dry goods are not all dated. This is an area that has not been fully addressed since the certification</li> </ul>	<p>Not all aspects of food preparation, storage, and disposal comply with current legislation and guidelines. All areas of the kitchen are in need of deep cleaning. Foods such as jellies and condensed milk stored in a fridge date back more than a week and the disposal of all food scraps (including meat) into pig bins does not meet relevant legislative requirements.</p>	<p>Food production, storage and disposal is undertaken according to safe practise and show compliance with current legislation and guidelines.</p> <p>90 days</p>

		<p>audit.</p> <p>Although the kitchen is of an older style, basic maintenance of scrubbing and cleaning are not being upheld. Accumulated food and grease is on the wheels of tray trolleys and kitchen wagons, around the feet of kitchen benches, tables and equipment, on the floors and around shelves and windowsills. The area presents as unhygienic and is in need of a deep clean. A list of kitchen cleaning duties is not available and current staff are not aware of any key responsibilities they have in this area beyond the basics.</p>		
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The tracers and some of the interviews undertaken demonstrate that service provision is occurring in a timely and competent manner. However, when the sample is extended there is evidence that this is not the situation for all residents, in particular those who require additional care or have an emergent problem. Four staff, and an externally based health professional, provided information during interview that suggests the monitoring and review processes have not always occurred in a manner that ensured early intervention. It is a required improvement that each stage of service provision occurs in a timely manner.</p>	<p>Assessment, planning, provision, evaluation and review is not consistently occurring to ensure service delivery is provided in a timely and safe manner, especially when a resident requires more advanced care(s). There are examples of residents' conditions worsening due to a lack of early interventions and the sample showed a high proportion of adverse events, such as skin tears and falls.</p>	<p>The monitoring and review of services being provided occur within timeframes that safely meet the needs of all residents.</p> <p>90 days</p>

<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Short term care plans are being developed and show interventions. Although most show that resolution has occurred and this is dated, there is no evidence of interim reviews and evaluations of these.</p> <p>Long term care plans show that a review process is in place and staff report monthly multi-disciplinary meetings for this purpose. Except for the reviews of activities and physiotherapy goals, the long term care plan reviews state no change, rather than inform of the degree of achievement, or level of response to the interventions and/or supports being provided. This is an area requiring improvement.</p>	<p>The review and evaluation of short term care plans is not consistently occurring and the evaluations of long term care plans do not describe the degree of achievement or response to the intervention, and progress towards meeting the residents' goals.</p>	<p>Short term care plans indicate progress with resolution of the identified problem and long term care plans clearly indicate the degree of achievement of the goal(s) and the response to the support and/or intervention.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>A feature of the Rannerdale War Veteran’s home strategic plan is that they are transitioning the focus of their services to one that uses a rehabilitation and restorative model. This is already having an impact on the activities programme, which is now showing evidence of continuous improvement. Highlights demonstrating this are that the management team are as follows:</p> <p>There is a significant allocation of additional hours to activity and therapy related programmes that have a rehabilitation focus. Currently two qualified occupational therapists and a physiotherapist are involved alongside therapy assistants and caregiving staff are also supporting these programmes. The rehabilitation team is in the process of completely re-evaluating the activities plans for all residents using professional functional</p>	<p>The implementation of an activities and therapy programme that is facilitating the service’s transition to one with a rehabilitation and restorative focus is demonstrating continuous improvement. This is evident with the increased number of qualified staff allocated for activities and physical therapy, the integration of caregivers into the therapy activities, the creative and innovative nature of options in the monthly activities programme, the availability of individualised and/or group options according to personal assessments following referrals, the re-assessment of all residents and the re-development of their individual activity plans and the ongoing assessment and review processes for individuals and for implementation of the programme.</p>

		<p>assessment processes. Individualised plans are being re-developed with the restorative model in mind. Referrals of residents with specific problems to the OTs and the physiotherapist are being accepted from registered nurses, the GP and external specialists who are aware of the availability of these specialties. A screening process is in place and decisions made as to what will be provided on a one to one basis and which will be group related.</p> <p>Monthly meetings of the rehabilitation team are occurring when the evaluation of residents' personal goals are evaluated and evaluation of the introduction of the new model is occurring. Documentation sighted affirms these processes. Two weekly multidisciplinary meetings with the clinical nurse manager and a senior healthcare assistant are also in place.</p> <p>The activities plan for November 2014 shows a comprehensive range of options are available for residents. Many of these demonstrate a creative approach and groups for activities such as relaxation, and hand therapy are meeting with approval from residents. There is an overall sense of excitement and ongoing improvement as this service strives to implement an activities programme with a difference.</p>	
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End of the report.