

# Rita Angus Retirement Village 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Rita Angus Retirement Village Limited
<b>Premises audited:</b>	Rita Angus Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 20 November 2014    End date: 21 November 2014
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	89

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

## General overview of the audit

Rita Angus is a Ryman Healthcare facility that provides rest home and hospital level care. The 69 beds in the care centre have previously been assessed as dual purpose. On the day of audit there were 20 rest home residents and 48 hospital residents in the care centre. In addition 20 serviced apartments had previously been assessed as suitable for rest home level residents. On the day of audit there were 10 rest home level residents in the apartments.

The village manager is suitably qualified and is supported by a clinical manager (registered nurse) who oversees the care centre. There are systems, policies and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme (RAP). An induction and in-service training programme is being implemented that provides staff with appropriate knowledge and skills to deliver care.

The service has addressed two of the six shortfalls from their previous certification audit around complaints and timely completion of wound plans. Further improvements continue to be required around incident reporting, care planning and evaluation.

This audit also identified improvements required around meeting minutes, documentation, activities and medication management.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is an open disclosure policy. Interviews with residents and relatives confirm family are kept informed of their family members current health status including any adverse events. A complaints process is being implemented and the shortfall from the certification audit has now been addressed.

## 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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Rita Angus is implementing the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Rita Angus provides clinical indicator data for the two services being provided (hospital and rest home). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual

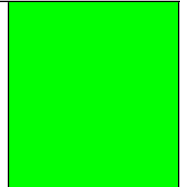
requirements and includes skill mixes. Further improvements continue to be required around incident reporting, and meeting minutes.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations are completed by the registered nurses within the required timeframe, monitoring forms are available. Care plans demonstrate service integration, are individualised and evaluated six monthly. The resident/family/whanau interviewed confirmed they are involved in the care plan process and review. Short term care plans are in use for changes in health status. The activity officers provide an activities programme in each unit that meets the abilities and recreational needs of the residents that is varied, interesting and involves the families and community. There is an improvement required to ensure all residents have an activities plan. There are policies and processes that describe medication management that align with accepted guidelines. Staffs responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Meals are prepared on site. The menu is designed by a dietitian at organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Nutritional snacks are available 24 hours for residents. Residents interviewed responded favourably to the food that was provided. Further improvements continue to be required around care planning, evaluation and medication management.

## 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 building warrant of fitness that expires 12 September 2015. There is a first aider on site at all times.

## 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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There are comprehensive policies and procedures that meet the restraint standards. There is a restraint officer who has defined responsibilities for monitoring restraint use. Restraint use is discussed at RN, staff and management meetings. There is restraint education at orientation and on-going. There are four residents with restraints in use and one resident with an enabler.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Ryman facilities. Staff receive on-going training in infection control.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	11	0	6	1	0	0
<b>Criteria</b>	0	40	0	6	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy is being implemented. The village manager has overall responsibility for ensuring all complaints are fully documented and thoroughly investigated. A feedback form is completed for each complaint recorded on the complaint register. The number of complaints received each month is reported monthly to staff via the various meetings – e.g. Caregivers, full facility, RN (link 1.2.3). The complaints register includes relevant information regarding the complaint. Documentation including follow up letters and resolution is available. Discussion with six residents and five relatives confirm they were provided with information on the complaints process. Feedback forms are available for residents/relatives in various places around the facility.</p> <p>The 14 complaints received across the 2014 year were reviewed. All have close out letters explaining the outcome of investigation. The actions reported in the close out letter were seen to have been completed – such as discussing at relevant staff meeting. The service has been active in addressing issues raised through complaints; two examples include the marked improvement in call bell response time and food services. A complaint in March reported a 40 minute response time to a call bell; call bell report for the week 6-12 March (the time of the complaint) showed 85 hospital and 13 rest home calls took in excess of 10 minutes to respond to. In comparison week 13-19</p>

		<p>November there were 13 hospital and 4 rest home calls that took in excess of 10 minutes. Interview with three residents also reported an improvement.</p> <p>The second QIP (Quality Improvement Plan) has been around food services. Issues were raised through complaint (January 2014), resident meetings and highlighted in the June 2014 relative survey. A book was put in each servery that care staff completed on residents behalf after meals, the chef reviews the feedback and makes adjustments. This initiative was verified through staff (three caregiver and the chef) and residents (five rest home, one hospital) interviews.</p> <p>Improvement: one written complaint about noise at night from a family reports the resident had made a verbal complaint about the matter and nothing had been done to resolve the matter. This does not appear on the register. The resident is no longer residing at Rita Angus and therefore could not be further explored. As there was no other evidence in interviews and documents reviewed in respect of verbal complaints being reported and not actioned, and the service is seen to be responsive to issues raised, this is considered to be an improvement rather than a finding.</p> <p>The finding from the certification audit relating to complaint management has been addressed.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an incident reporting policy, and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. The incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed (across both service levels) identified that family were notified following a resident incident. Interpreter policy and contact details of interpreters are available.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b Five relatives (hospital) stated that they are informed when their family</p>

		<p>members health status changes.</p> <p>D11.3 The information pack is available in large print and this can be read to residents.</p>
<p><b>Standard 1.2.1: Governance</b></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>Rita Angus provides care across two levels. The 69 beds in the care centre have all previously been assessed as dual purpose. On the day of audit there were 20 rest home residents and 48 hospital level residents. In addition 20 serviced apartments have previously been assessed as suitable for rest home level residents and on the day of audit there were ten rest home residents in apartments. There is a medical component to the certificate. There is a contracted physiotherapist for 12-15 hours per week and a physiotherapist assistant that works 15 hours per week. There is a contracted medical centre that provides as required services.</p> <p>There is a documented ' purpose, values, scope, direction &amp; goals policy. Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation wide objectives are translated at each Ryman service by way of the RAP that includes a schedule across the year for the following areas: a) RAP Head Office, b) general management, c) staff development, d) administration, e) audits/infection control/quality/compliance/health and safety and f) Triple A/activities. Ryman Healthcare have operations team objectives 2014 that include a number of interventions/actions for; a) quality system focus forward, b) national dementia project, c) human resources - recruitment/induction processes, d) health and safety, e) InterRAI project, and f) clinical education. Each service also has its own specific RAP objectives. 2014 objectives for Rita Angus include a focus on reducing skin tears and falls.</p> <p>The village manager has been in post for 17 months and has a background in sales. He has completed specific manager orientation with Ryman and attends the annual Ryman manager's conference. He is supported by an assistant manager who carries out administrative functions and a clinical manager (RN) who oversees clinical care at the care centre. The clinical manager has been in post two months, and was previously the duty manager/hospital coordinator at Rita Angus. A new hospital coordinator has been appointed and commences 24 November. The management team is supported by the Ryman management team including regional manager.</p> <p>The management resource manual includes a number of documented responsibilities of the manager including a list of reporting requirements. There is a manager's job description that includes authority, accountability and responsibility including reporting requirements. The Ryman managers complete a Leadership and Management course</p>

		(an initiative by Ryman) that includes a number of modules. Management development programme includes self-directed learning packages.
<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>	PA Low	<p>Rita Angus is implementing the Ryman RAP system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP Committee, full facility, registered nurse and caregivers. Issues are also reported through the weekly management meetings and a weekly report is provided to the regional manager.</p> <p>The service has policies and procedures and the RAP programme defines systems to provide an assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All facilities have a master copy of all policies &amp; procedures with associated clinical forms. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow implementation by staff. A number of core clinical practices have staff comprehension surveys that staff are required to complete to maintain competence/knowledge and education packages which are based on their policies. Policy and procedure review is coordinated by head office, with facility staff having the opportunity to provide feedback (staff interview). Facility staff are informed of changes/updates to policy at the various staff meetings.</p> <p>Key components of the quality management system link to the RAP committee at Rita Angus who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports to that are sent to head office (Christchurch) provide a coordinated process between service level and organisation. There are monthly accident/incident reports completed by the clinical manager collected across the rest home and hospital services, there are instances where the service reports do not match VCare and this is an area for improvement. The service has linked the complaints process with its quality management system and communicates this information to staff at relevant meetings so that improvements are facilitated. Weekly and monthly manager reports include complaints. The Rita Angus combined health and safety and infection control committee meet monthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation. Meeting minutes do not consistently record sufficient detail.</p> <p>Rita Angus is implementing the RAP quality and risk programme with monitoring being determined by the internal audit schedule. Audit summaries and quality improvement</p>

		<p>plans (QIP) are completed where a noncompliance is identified. Repeat audit is required if results exceed the Ryman threshold (92%). Issues and outcomes are reported to the appropriate committee e.g. RAP. There is evidence of trending of data collected and QIPs being developed when volumes exceed targets – eg. falls and pressure areas. Weekly reporting to the regional manager includes bed state, staffing and incidents/complaints that meet the reporting threshold in the Ryman risk matrix. QIP's reviewed are seen to have been closed out once resolved.</p> <p>D19.3: There is a comprehensive H&amp;S and risk management programme in place. There are policies to guide practice.</p> <p>D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hi/lo beds, assessment and exercises by the physiotherapist and sensor mats.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>D19.3c: The service collects incident and accident data. Twelve incident forms were reviewed between September and November across both service levels. The forms were fully completed, including RN comment and close out. This aspect of the shortfall from the certification audit has been addressed. Neuro observations were seen to have been undertaken appropriately, and transfer to DHB services when required. Four resident files were traced (two hospital and two rest home) and there were incidents recorded in the progress notes that did not have an associated incident form and this is a recurring area requiring improvement. D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Corrective actions were cited for incidents above the benchmark for example falls. Corrective action plans were completed and signed off. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Relevant documentation is seen in eight staff files reviewed (clinical manager who is the restraint coordinator and infection control coordinator, one registered nurse, three caregivers,</p>

<p>practice and meet the requirements of legislation.</p>		<p>one activities coordinator, chef and the serviced apartment coordinator who is an enrolled nurse). Additional role descriptions are in place for infection control coordinator, restraint coordinator, in-service educator, and health and safety officer, fire officer. There is a schedule to manage performance appraisals that is seen to be being implemented.</p> <p>Policy: Health practitioners and competencies outline the requirements for validating professional competencies. A register of practising certificates is maintained. Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering.</p> <p>There is a 2014 training plan developed for Rita Angus that is aligned with the RAP. Staff education and training includes the ACE programme for caregivers. Ryman ensures RNs are supported to maintain their professional competency. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on. Ryman has a 'Duty Leadership' training initiative that all RNs, ENs and Senior Leaders complete. It includes four modules/assignments around resident rights, customer service, leading colleagues and key operations/situations.</p> <p>The clinical structure in the facility includes a clinical manager, a registered nurse coordinator in the hospital (commencing 24 November) and a team of registered nurses and care staff. The serviced apartments (where there is currently ten rest home level residents) have a coordinator (enrolled nurse).</p> <p>Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff and actively support the Health Ed Trust ACE Programmes and provide incentives to their staff to undertake both the general and dementia modules. Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy 2.7.1 Staff Administration identifies manager availability including on call requirements. The policy also includes the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Interviews with three caregivers inform the RN's are supportive and approachable. In the care centre there are: AM - three registered nurses and 13 caregivers working various shifts, PM - two registered nurses and 11 caregivers working various shifts; ND – one RN and four caregivers (all full shift). The hospital coordinator works Tuesday –</p>

		<p>Saturday, and the clinical manager Sunday – Thursday. The serviced apartments have caregivers between 0700 and 2230 after which the rest home staff provide support. There are three activity coordinators. Interviews with staff, residents and relatives inform there is sufficient staff on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. 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 by being held in a locked cupboard in both areas. Care plans and notes are legible and where necessary signed (and dated) by RN. Policies contain service name. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p> <p>D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. There are signing and dating gaps in supporting documentation and resident medication charts are in public area.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The service uses individualised medication blister packs for regular, “odd time” medications and PRN medications. Two medication rooms are viewed (rest home and hospital) and one medication cupboard (serviced apartments). All medications rooms are secure. Medications trolleys are locked. Contents are all within expiry dates and eye drops are dated on opening. Expiry dates of all medications are checked monthly. There is a specimen signature list of all medication competent persons. The EN serviced apartment co-ordinator and caregivers administer medications in the serviced apartments. RN’s administer medication in the care centre. Staff attend medication training and complete medication and insulin competencies. RNs complete syringe driver training. There are current standing orders.</p> <p>Medications to be returned to the pharmacy are stored securely until collected by the pharmacy. Medication fridge’s are monitored weekly (records sighted). Oxygen, suction and emergency trolley in the hospital unit is checked and signed off (as sighted). PRN medications have the time of administration on the signing sheet. Controlled</p>

		<p>drugs are signed by two persons. Dietary supplements, antibiotics and short course have signing sheets. Twelve medication charts sampled (two serviced apartment (rest home level), four rest home, six hospital) include PRN medication and the indications for use. One (of 12) medication charts did not have medication charted correctly, and one chart (of 12) was not legible. Medication charts have photo identification (dated) and allergies/adverse reactions documented. D16.5.e.i 2; 12 Medication charts reviewed identified three monthly medication reviews signed by the attending GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a qualified chef who works 0730-1600 Monday to Friday and a cook working the same hours at the weekend. The chef/cook is supported by a chef assistant 0800-1400 and a morning and afternoon kitchen hand each day. There is a four weekly seasonal menu that has been designed and reviewed by a dietitian at organisational level. The chef receives a resident dietary profile for all new admissions and is notified of dietary changes following the six monthly reviews and at other times such as resident with weight loss/weight gain or swallowing difficulties. Resident likes, dislikes and dietary preferences are written up on the kitchen whiteboard. Normal, mouli, diabetic diets, dairy free and gluten free diets are provided. Food is delivered in hot boxes to the kitchenettes and dining areas in each area and served from bain maries. Caregivers serve the meals and have a resident like/dislike list in each dining area. The chef plates and labels special diets. Nutritious snacks such as desserts, yoghurt, custard, biscuits and sandwiches are available over 24 hours for residents. Staff are observed sitting with the resident when assisting them with meals.</p> <p>The service has a large workable kitchen with a separate dishwashing area, baking, cooking and storage areas, a large chiller, freezers and freezers, walk-in pantry, two combi ovens and gas oven. All foods are date labelled in the freezers and fridges. Dry goods in the pantry are sealed and date labelled. There is a three monthly clean of the large dry goods bins. Fridge and freezer temperatures are recorded daily. Facility food fridges are monitored weekly. Hot food temperatures are recorded daily. Room temperatures are monitored. There is a cleaning schedule in place (sighted) which is signed off as duties are completed. Staff are observed wearing aprons, hats and gloves.</p> <p>The kitchen equipment is on a planned maintenance schedule. The preferred supplier provides chemicals, safety data sheets and chemical safety training as required. Quality control checks are carried out on the dishwasher. Chemicals are stored safely in the kitchen.</p>



		<p>There is a food service manual that includes (but not limited to); food service philosophy, food handling, leftovers, menu, dishwashing, sanitation, personal</p> <p>Feedback on the service is received from resident and staff meetings, surveys and audits.</p> <p>D19.2: Staff have been trained in safe food handling and chemical safety.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>An initial support plan is completed within 24 hours. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k) social, spiritual, cultural and sexuality. Improvement is needed in consistently completing all sections of the LTCP with all assessed problems of the resident. Interview with five registered nurses and the clinical manager verified involvement of families in the care planning process. Resident/family/whanau involvement is evidenced by written acknowledgment of care plan involvement.</p> <p>Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as speech language therapist, physiotherapist, podiatrist and dietitians. Activity officers maintain activity assessment/activity plans and evaluations in residents file. There are specific physiotherapy progress notes and podiatry visits are documented.</p> <p>D16.3k: Short term care plans are in use for changes in health status (link 1.3.8). Examples sighted are as follows: weight loss, skin tear, chest infection and UTI.</p> <p>D16.3f: Six resident files reviewed (three hospital and three rest home) identified that the resident/family are involved in the development/evaluation of care plans. Relatives interviewed (five hospital) confirm they are involved in the care planning process</p> <p>This is a recurring issue from the certification audit.</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</p>	<p>FA</p>	<p>Residents interviewed (five rest home, one hospital) report their needs are being appropriately met. Relatives interviewed (five hospital) state their relatives needs are being appropriately met and they are kept informed of any changes to health and</p>

<p>desired outcomes.</p>		<p>interventions required. This is evidenced in the progress notes with a “relative contact” stamp.</p> <p>D18.3 and 4: Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment and wound treatment and evaluation plans are in place for one resident in the rest home with two grade one sacral pressure areas; and six wounds in the hospital. Wounds unresolved after seven days are transferred to the LTCP. A wound and skin tear register is maintained. All documented wounds and skin tears have been evaluated the required timeframe as documented (link 1.3.8). The clinical manager is the “wound champion” for the service offering advice and education for all staff on wound care management. There is also has access to external to wound specialist as required and one of the documented wounds is being managed by the wound specialist district nurse who documents and discusses treatment with the RN on duty. Wound care management training is provided for the RNs.</p> <p>Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the five RN's and Clinical Manager interviewed.</p> <p>Weigh chair scales (calibrated) are used to weigh residents monthly or more frequently for the monitoring of weight loss/gain (link 1.3.5).</p> <p>Coombes falls risks assessments are carried out on admission and reviewed at least six monthly or earlier if an increase in risk level is identified. The physiotherapist completes an assessment form for at risk residents. Accident /incidents are investigated for cause and corrective actions including a physiotherapist review, the use of sensor mats, hip protectors, clutter free rooms and mobility aids available.</p> <p>Residents identified with behavioural or challenging behaviour have a behavioural assessment completed and behaviour nursing care plan that identifies the behaviour, triggers and interventions including activities over a 24 hour period that can be best used to manage behaviours. Behaviour monitoring charts are in place to monitor behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the</p>	<p>PA Low</p>	<p>There are four activity coordinators (one in training) that provide a separate activity programme for the rest home, hospital and serviced apartments. They provide a seven day programme with at least one activities staff member on every day. There are set calendar events and expectations for each area including the triple A exercise</p>

<p>setting of the service.</p>		<p>programme which is applicable to the cognitive and physical abilities of the resident group. The programme is planned monthly and residents receive a personal copy of planned monthly activities as well as a copy of what is happening weekly. Activities planners are printed in large print on A3 paper and are displayed on notice boards around the facility.</p> <p>There is an activities section in the resident file that include an activities assessment, 'your life experiences', next of kin input into care and an activities plan. The plan includes categories for comfort and wellbeing, outings, interests and family and community links. In two of six files reviewed there is no activities plan.</p> <p>There is a comprehensive programme that meets the needs of all consumers including but not limited to; news, reminiscing, triple an exercises, lounge games, carpet bowls, arts and crafts, board games, weekly movies in the cinema, cooking club, gardening club, happy hours and weekly sing-a-longs and entertainers. Rest home and hospital residents mix and mingle as desired. One on one time is spent with residents who choose not to participate or who choose not to join in group activities.</p> <p>Residents are encouraged to maintain links with the community and there is contact with groups such as the blind foundation, stroke foundation, Alzheimer's group and library. Church services are held weekly. There are regular outings and scenic drives for residents. Festive occasions, special events and resident birthdays are celebrated. The programme is reviewed weekly with Triple A attendance sheets being forwarded to head office. All six residents and five family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p> <p>D16.5d. Resident files reviewed identified that the individual activity plan is reviewed at care plan review.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The evaluation and care plan review policy require that care plans are reviewed six monthly. The written evaluation template describes progress against every goal and need identified in the care plan (sited in five of six resident files). Short term care plans are generally used for short term changes in health status at the facility. Short term care plans in use were seen to have been evaluated regularly and resolved or added to the long term care plan if an on-going problem. There are instances where a STCP was not in place for short term issues. Any changes to the long term care plan are dated and signed. Family are invited to attend the multidisciplinary review meetings (correspondence noted in files reviewed – link 1.2.9). Resident medications and</p>

		<p>medical status are reviewed at least three monthly by the general practitioners.</p> <p>D16.4a: In five of six files reviewed the LTCP has been evaluated six monthly more frequently when clinically indicated. One LTCP had not been evaluated for eleven months and there is a required improvement.</p> <p>Evaluation of care is a recurring issue from the certification audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that will expire 12 September 2015. Building compliance checklists are being completed monthly and daily egress checks are completed (sighted). There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and electrical testing. Hot water temperatures in resident areas are monitored monthly.</p> <p>ARC D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, standing and lifting hoists, mobility aids, transferring equipment, sensor mats, electric beds, ultra-low beds, hospital level specialised lazy boy chairs on wheels and weighing scales</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the RAP. The results are subsequently included in the village manager's report. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</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>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service currently has four residents who have been assessed as requiring the use of five restraints (bedrails and chair brief) and one resident with an enabler (bedrails). A monthly restraint and enabler register is maintained. The long term care plan a restraint section which details the use of restraint/enablers, frequency of monitoring and required documentation. There is restraint monitoring guidelines in place. Accuracy in completing all sections, including times and signatures, is required on the restraint monitoring form (link 1.2.9).</p> <p>Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the restraint approval and review process. The clinical manager is the restraint officer. Types of restraint have been approved for use by the restraints committee. The service is able to evidence a successful trial of removal of restraint.</p> <p>Restraint use is included in the orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice is included in the core competencies. Staff have attended restraint in-service within the last year.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The RAP programme prescribes the meeting structure for Rita Angus and there is evidence these are being implemented as prescribed. All meetings are minuted. There are inconsistencies noted in the minutes reviewed including (but not limited to) the following: a) insufficient detail to describe the discussion and/or outcome – e.g. full facility meeting 17 September; item Village Objectives minutes report ‘general discussion had’; b) inconsistent follow through meeting to meeting – e.g. Full facility meeting 16 April, records Food Diary – diary put at each server. Full facility meeting 28 August, item House Rules – house rules have been updated; all staff to collect sign and return; c) meeting minutes include incident/accidents and record ‘refer attached report’, meeting minutes (full</p>	<p>Meeting minute’s inconsistently record sufficient detail of discussions and outcomes; and month-to-month follow through on actions. In addition incident/accident monthly data is not always attached to minutes as recorded.</p> <p>The monthly clinical indicator data recorded in service reports, on occasion differs from that reported in VCare for the same period/s.</p>	<p>Ensure meeting minutes record discussion and outcomes as well as follow up on outstanding actions. Ensure clinical indicator data recorded through VCare is representative of the incidents occurring at service level.</p> <p>180 days</p>

		<p>facility) 19 September and 16 April do not have the relevant reports attached.</p> <p>Incident forms are completed following a resident event. Completed forms are then entered into VCare and monthly data against clinical indicators is reported back to the service. A more detailed monthly report is also generated by the service that is discussed at the various meetings. There are instances where the data on the service report differs from the data generated through VCare – for example: In May the service reports 30 incidents for hospital residents, VCare reports 29; June service reports 42 hospital incidents and VCare 48. Rest home – May the service reports nine incidents and VCare 10; June service reports 12 incidents and VCare 14.</p>		
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Twelve incident forms were reviewed between September and November across both service levels. The forms were fully completed, including RN comment and close out. Interventions were seen to have been recorded such as neuro observations following a possible head injury, and transfer to DHB services when required. Four resident files were traced (two hospital and two rest home) and there were behavioural incidents recorded in the progress notes for two residents that did not have an associated incident form.</p>	<p>There were behavioural incidents recorded in progress notes where the related incident form could not be located.</p>	<p>Ensure resident incidents are recorded on the prescribed form.</p> <p>90 days</p>

<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	<p>PA Low</p>	<p>In four (of six) resident files all clinical documentation is dated and/or signed.</p> <p>The rest home residents in the serviced apartments have clinical records and medication charts kept in the nurses' station in the proximity of the apartments. While the clinical records were secured out of view, the medication charts were left in an open nurses' station.</p>	<p>There are signing and dating gaps in supporting documentation and resident medication charts are in public area.</p>	<p>Sign and date clinical documentation. Secure medication charts out of public view.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>The service has policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. Twelve medication charts were reviewed.</p>	<p>One medication chart was not legible due to repeated faxing. One medication chart did not include all medications the resident required and the staff were administering one medication from a discharge summary – this was corrected on the day of audit.</p>	<p>All medication charts are to be legible and include all required medications</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>LTCP's are developed for all residents within required timeframes. The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. There is a long term nursing care plan that includes; a) cognitive/mood, b) sensory/communication, c) mobility, d) safety/risk, e) respiratory/cardiac, f) continence, g) medication, h) ADLs, i) skin, wound and pressure care, j) dietary/diabetes management, and k)</p>	<p>In three of six resident files the LTCP did not accurately reflect management of the resident current care needs. In four of six resident files the LTCP's were either incomplete or showed inconsistency across the sections: eg. one plan did not record resident regular attendance at the Chelsea club, one plan recorded 'normal textured diet' under the nutrition section, but records 'high calorie and diabetic diet' in the</p>	<p>Ensure individual resident needs are accurately recorded in the LTCP and/or a STCP</p> <p>90 days</p>



		social, spiritual, cultural and sexuality.	diabetes section of the plan.	
<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>	PA Low	Four of six files sampled had a full activities assessment and care plan.	Two of six resident files sampled had no activities care plan, one was admitted in May, 2014 and the other September 2014.	<p>Ensure all residents have an activities care plan developed within required timeframes.</p> <p>60 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>	PA Low	Five of six resident files sampled had evidence of short term care plans when required.	One resident who required a laceration from a fall to be sutured in hospital did not have a STCP or wound management plan developed.	<p>Ensure STCP's and wound management plans are completed when a change in skin condition is observed.</p> <p>90 days</p>

## 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.