# Rannerdale War Veterans Home Limited - Rannerdale War Veterans' Hospital and Home

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Rannerdale War Veterans Home Limited

**Premises audited:** Rannerdale War Veterans' Hospital and Home

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

**Dates of audit:** Start date: 2 May 2016 End date: 3 May 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 49

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Rannerdale War Veterans' Hospital and Home cares for up to 61 residents. The service is certified to provide care across three levels (hospital-medical/geriatric, rest home and residential disability level care). On the day of the audit, there were 49 residents.

The service is overseen by a general manager, who is well qualified and experienced for the role and is supported by an acting director of nursing, a clinical charge nurse (on leave during the audit) and an operations manager. Residents and families interviewed spoke positively about the service provided.

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

This audit has identified areas requiring improvement around open disclosure, clinical follow-up of incidents, resident meetings, corrective action planning, staff training (including first aid certificates), signing and dating documents, chemical storage, timeliness of clinical documentation, care planning, care interventions 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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff at Rannerdale strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## 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 medium or high risk and/or unattained and of low risk. |

The general manager is a registered nurse. The quality and risk management programme includes service philosophy, goals and a quality plan. Quality activities are conducted. Meetings are held to discuss quality and risk management processes. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

Rannerdale has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. An authorised technician has calibrated medical equipment and electrical appliances. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner’s room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

## Restraint minimisation and safe practice

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

Rannerdale has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint and one resident with an enabler. Enabler use is voluntary.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are beginning to be acted on, evaluated and reported to relevant personnel in a timely manner.

## 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** | 0 | 34 | 0 | 7 | 4 | 0 | 0 |
| **Criteria** | 0 | 79 | 0 | 9 | 5 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (five healthcare assistants, one registered nurse (RN), one occupational therapist, one physiotherapist, one activity staff, one acting director of nursing, one general manager and one operations manager) confirm their familiarity with the Code. Interviews with 11 residents (four rest home, four hospital and three younger people) and three families (all hospital) confirm the services provided are in line with the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are policies in place for informed consent and resuscitation and the service is committed to meeting the requirements of the Code of Health and Disability Services Consumers’ Rights. There were signed general consents including outings on all seven resident files sampled. Advance directives were appropriately signed in the files reviewed.  Discussions with staff confirmed they were familiar with the requirements to obtain informed consent for personal care and entering rooms.  Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents (including younger people) are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents and family members interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Verbal and written complaints are documented. Complaint forms were reviewed (all four complaints since July 2015). All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Three complaints were made to the Health and Disability Commissioner in 2015. All are now closed with no further actions required. HealthCERT requested that complaint management processes be reviewed during this audit following one of the HDC complaints. Complaint management processes meet requirements. Discussions with residents confirmed that any issues are addressed and they feel comfortable to raise any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the code of rights on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the registered nurses discuss the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code of Rights. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.  A policy describes spiritual care. Church services are regularly conducted in the facility. All residents interviewed indicated that resident’s spiritual needs are being met when required.  Not all staff have completed training around recognising abuse and neglect (link 1.2.7.5). Interviews with staff confirmed understanding of the abuse & neglect policy. There have been no reported incidents of abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Four residents identified as Māori on the day of the audit.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service has established cultural policies aimed at meeting the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.  Information gathered during assessment including residents cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards, for residents with aged care and residential disability needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects good levels of satisfaction with the services provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged and residential disability care and stated that they feel supported by the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed (a sample from March). The forms included a section to record family notification. Not all forms indicated family were informed or if family did not wish to be informed. Residents and family members interviewed confirmed that relatives are notified of any changes in their family member’s health status as far as they were aware. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Rannerdale War Veterans' Hospital and Home provides hospital, rest home and residential disability (physical) level care for up to 61 residents. On the day of the audit, there were 49 residents. This includes 23 rest home level residents (including five on long-term chronic care contracts) and 16 hospital level residents (including four on long-term chronic care contracts and one person funded by ACC). Additionally, there are 10 residents on younger persons with disability contracts (five at hospital level care and five at rest home level care). All downstairs rooms (46 rooms) are dual purpose and 15 upstairs rooms are for rest home level care.  The general manager is a registered nurse and maintains an annual practicing certificate. He has been at Rannerdale for 14 years. He is supported by a long-term operations manager (not clinical) and acting director of nursing (previously in a quality and training role), and a clinical charge nurse who was on leave during the audit.  Rannerdale has a strategic plan in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The general manager has completed in excess of eight hours of professional development in the past 12 months. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the general manager, the operations manager is in charge, with support from the acting director of nursing and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is an organisational strategic plan that includes quality goals and risk management plans for Rannerdale. Interviews with staff confirmed that quality data in clinical leadership meeting minutes is provided on notice boards for all staff to read. The operations manager advised that he is responsible for providing oversight of the quality programme with support from the clinical management team. The quality and risk management programme is designed to monitor contractual and standards compliance. The management team, with input from facility staff, reviews the service’s policies every two years. Policies have been updated to include InterRAI assessment requirements. Staff have access to manuals. Monthly resident committee meetings are held but not all residents have input into these. Restraint and enabler use is reported within the clinical leadership meetings.  Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities have not always had corrective action plans developed.  The service has a comprehensive health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low | There is an accidents and incidents reporting policy. The acting director of nursing or operations manager (depending if the issue is clinical or not) investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly clinical leadership meetings including actions to minimise recurrence. A registered nurse conducted clinical follow-up of residents on seven of ten incident forms sampled. All ten incident forms sampled demonstrated investigation of incidents to identify areas to minimise the risk of recurrence. Discussions with the general manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One sudden death was referred to the coroner in March 2016. The coroner’s inquiry is now closed for this matter. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | There are human resource management policies in place, and include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (three healthcare assistants, one rehabilitation assistant, two registered nurses, the activities coordinator and a laundry person) and these evidence appropriate employment practices including that reference checks were completed before employment is offered. Not all staff files sampled had completed current performance appraisals. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme is being implemented but not all staff have received the required training. The registered nurses are able to attend external training, including sessions provided by the local DHB. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is on duty at any one time. A member of the management team is on call at all times. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | 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. Resident files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible but not always dated and signed by the writer. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team and this was included in the seven files reviewed (four hospital including one younger person disabled and three rest home including one younger person disabled). A registered nurse completed an initial assessment on admission. The service has specific information available for residents and families at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer/discharge/exit procedures includes a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation were forwarded with the resident. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service uses individualised medication packs, which are checked against the drug chart on delivery. A registered nurse and caregiver were observed administering medications correctly. Medications and associated documentation are stored safely and securely and all medication checks were completed and met requirements. Eye drops were not always dated when opened. Resident photos and documented allergies or ‘nil known’ were on all 14 medication charts reviewed. Not all staff who administer medication have an up-to-date medication competency and syringe driver training and competencies have not been completed by RNs. Not all medication storage, medication documentation and signing for medication on administration conformed to standards. The medication assessment for self-medication residents and a process for YPD residents to achieve self-medication were not in place  Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The contracted meal service provider prepares and cooks all meals on site. There is a four weekly winter and summer menu, which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Food services staff know resident dietary profiles, and likes and dislikes and any changes are communicated to the kitchen via the registered nurse or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The reason for declining service entry to residents would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident and family and the appropriate referrer. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which forms the basis of resident goals and objectives. Paper assessments are reviewed at least six monthly for all residents (link to 1.3.3.3 for InterRAI assessments). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The long-term care plan template records the resident’s problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that includes short-term cares. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Care plan interventions were not fully documented or personalised in all files reviewed.  The service continues to add to care plans, and although all information was legible, there was some confusion around current care needs. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Interviews with residents and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management (link 1.3.5.2). Specialist continence advice was available as needed and this could be described. Monitoring charts were not fully utilised and not all wound assessment and wound management plans included appropriate documentation. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The physiotherapist, the occupational therapist, the activities coordinator and activities staff provide an activities programme. The programme links to the restorative focus of the services and enables strong community links for the residents. Residents funded through the MOH disability contract have extra support to assist them to connect to the community and enable social interaction with peers (link 1.3.5.2). Residents interviewed confirmed that they are assisted to access outside interests.  The monthly programme is displayed on noticeboards around the facility. A diversional therapy plan has been developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are appropriate and meaningful and residents are encouraged to participate in community activities. The service has a van used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed were updated as changes were noted in care requirements (link 1.3.5.2). Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care plans were utilised for residents and any changes to the long-term care plan were dated and signed (link 1.3.5.2). Care plans reviewed were evaluated within the required timeframes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals however not all chemicals were stored safely. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness. Hot water temperatures are checked regularly. Medical equipment and electrical appliances have been tested and tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms are single rooms. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Resident rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Healthcare assistants interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge, plus other lounges and dining areas for the residents. The dining room is spacious. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff have attended infection control education and chemical safety training. There is appropriate protective clothing available. Manufacturer’s data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | The service has policies and procedures around fire and emergencies. There is an approved fire evacuation scheme. Fire safety training has been provided. There is an effective call bell system in place. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. Sufficient water is stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks have been conducted each night by staff and a contracted firm. There is not always a trained first aid responder on duty. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Rannerdale has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The acting director of nursing is the designated infection control coordinator with support from the infection control team. Minutes are available for staff. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The acting director of nursing at Rannerdale is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred (link 1.2.7.5). The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the infection control meetings. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the general manager. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraint and one resident with an enabler. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The registered nurse is expected to notify family of incidents as confirmed in policy and by the acting director of nursing. This had occurred on three of ten incident forms sampled. | Seven of ten incident forms sampled did not document that family had been notified of the incident. | Ensure that families are notified of all incidents.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Regular resident committee meetings are held for a small group of residents. It is the intention that these residents represent all residents. However, resident interviews demonstrated that not all residents feel they have input or get feedback from these meetings. | Not all residents interviewed were aware of resident committee meetings or aware of how to have input into them or get feedback from them. | Ensure that resident meetings held allow input from and feedback to all residents.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | When shortfalls are identified from complaints or incidents, a plan to address them is developed and addressed as part of the electronic process before the incident or complaint is closed. For internal audits, corrective action plans are developed for areas identified as high risk, but not for other identified shortfalls. | Corrective action plans are not developed for all shortfalls identified from internal audits. | Ensure that corrective action plans are developed for all identified shortfalls.  90 days |
| Criterion 1.2.4.3  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. | PA Low | When an incident is noted the person that finds the incident (usually the healthcare assistant) completes an incident form and healthcare assistants interviewed reported they leave these for the registered nurse on duty. Seven of ten forms sampled documented follow-up by the registered nurse. | Three of ten incident forms sampled did not document clinical follow-up from a registered nurse. | Ensure a registered nurse follows up all incidents.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | An in-service training programme is provided but several groups of staff have not attended and not all required training has been provided. Six of eight staff files sampled had completed performance appraisals. | A: Not all staff have attended training.  (i) No registered nurses have attended training around cultural safety, resident rights, infection prevention and control and skin integrity and pressure injury care. Only one registered nurse has attended abuse and neglect training and only two have attended wound management training.  (ii) No night staff attended training in 2015 (noting that self-directed packages around manual handling and restraint had been completed).  (iii) Staff attendance numbers at compulsory trainings are low. For example, in 2015 seven HCAs attended infection control training, nine cultural safety and resident rights training and 11 skin-management and pressure injury training.  (iv) No training has been provided around working with younger residents including around sexuality needs.  B: Two of eight staff files sampled did not have current performance appraisals completed. | A: Ensure staff complete all required training.  B: Ensure all staff have a current performance appraisal.  90 days |
| Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | All entries into progress notes, care plans and evaluations are dated and signed, but mobility and ADL plans and MDT records are not. | Multi-disciplinary team meeting records and ADL and mobility plans (kept in resident rooms), are not dated or signed by the person completing them. | Ensure all documents are dated and signed.  90 days |
| Criterion 1.3.12.1  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. | PA Moderate | There are comprehensive policies and procedures in place to guide staff through all processes around all aspects of the medication process. However, medication documentation and administration processes do not always meet requirements. | (i) Three eye drops were opened and not dated.  (ii) Three of the seven hospital level charts had ‘no indications’ for use with ‘as required’ medication.  (iii) One rest home level eye drops had been discontinued as staff stated the hospital advised this. There were GP instructions or documentation for this.  (iv) One rest home resident chart included instruction to increase medication if condition worsened, but no instruction was given as to dose or what resident symptoms were, to be taken into consideration.  (v) Three rest home and one hospital chart had no allergies documented (or nil allergies).  (vi) One rest home resident had a medication withheld but was signed as given. | (i) Ensure eye drops are dated on opening  (ii) Ensure indications for use are documented with ‘as required’ medications.  (iii) Ensure that all medication instructions are documented and endorsed by the specialist/GP.  (iv) Ensure medication prescriptions document all instructions for use when a variable dose is considered.  (v) Ensure allergies (or nil allergies) are documented.  (vi) Ensure that medications are signed-for correctly.  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | There are procedures, policy and tools in place to ensure that staff who administer medication are assessed as competent for this task. Not all staff who administered medications have appropriate competencies. | One healthcare assistant, who administers medication and the acting director of nursing (who assesses staff competency), did not have an up-to-date medication competency. Syringe driver training and competencies were not documented for RNs in the last two years. | Ensure that staff who manage or administer medications have an up-to-date medication competency including competency for syringe drivers.  30 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | The service has a rehabilitation model of care and has policies and procedures in place to ensure the safe self-administration of medication by residents. | Two residents who self-medicate did not have an assessment/competency in place. Two YPD residents did not have a process or action plan in place to assist them to be able to self-medicate. | Ensure that residents who self-medicate are assessed as competent to do so. Ensure that YPD residents have a process in place to fully-assist them to achieve their goal such as self-medicating.  30 days |
| Criterion 1.3.3.3  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. | PA Low | The nursing care assessments and long-term care plans are to be completed within three weeks and align with the service delivery policy. The service is in the process of implementing the InterRAI assessment process. | Two of four residents under the ARC contract did not have an InterRAI assessment (both hospital). Of the two residents with an InterRAI assessment, one was not within 21 days of admission. | Ensure that all residents’ InterRAI assessments are within set timeframes.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All resident files reviewed had a long-term care plan in place but not all required interventions were documented. The service uses a template that allows RNs to indicate care needs against a series of statements. Activities of daily living interventions were documented in all files. Not all short-term care plans documented specific care needed. | The following shortfalls were identified in the seven care plans reviewed (i) Two YPD residents (one hospital and one rest home level) had goals identified but no process or plan to assist with achieving the goals, or indication of progress. (ii) The same hospital YPD resident care plan has incorrect information with regard to hearing ability. (iii) One Insulin dependent rest home resident had no information around recognition and treatment of hypoglycaemia. This same resident has an indwelling catheter with no care plan interventions for care. (iv) One hospital level resident care plan documents that the resident is independent with care, but the resident’s health status has changed and the care plan not updated to reflect that. (v) The service updates changes of health status by adding to care plans. There is little space to continually add changes, and this has led to discrepancies around the current health needs and what is obsolete. (vi) One YPD resident’s (rest home) short-term care plan post-surgery did not include instruction for specific risks or care need. | Ensure that care plan interventions reflect the resident’s current need and that all information is clear and easy to read.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | All residents with wounds had a documented wound care assessment and management plan, but there was not individual documentation for every wound. This included four residents with pressure injuries, four residents with skin tears and two surgical wounds. The service has introduced new wound care charts and these are in the process of implementation. Required monitoring is documented in care plans but evidence of implementation was not consistent. Short-term care plans are completed (link 1.3.5.2), but are not available to care staff. | (i) Staff interviewed stated that short-term care plans were not readily available to healthcare assistants.  (ii) One rest home level resident with instructions for weekly weights had not had these undertaken consistently. One hospital level resident did not have documented turning charts or fluid balance charts as directed.  (iii) Two of twelve wound care plans had more than one wound documented on the assessment and management plan. A specialist nurse was undertaking one wound dressing. There was no documentation regarding this wound for the staff on site. | (i) Ensure that short-term care plans are available to healthcare assistants.  (ii) Ensure that care is documented as taking place as directed.  (iii) Ensure that wound care documentation is as per policy and specialist providers includes status and plans for the home-based clinical team.  60 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | There are secure storage areas for all chemicals but chemicals are not always stored securely. Housekeeping trollies are locked away when not in use | During frequent walk-arounds of the service, it was noted that the sluice door was frequently left open and chemicals not locked away. | Ensure that chemicals are secured safely.  30 days |
| Criterion 1.4.7.1  Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | The service has policies and procedures around fire and emergencies. Fire safety training has been provided but there is not always a trained first aider on duty. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. | The service utilises the services of agency registered nurses. On the shifts where agency nurses are the lead practitioners, there is no member of staff with a first aid certificate. | Ensure there is a qualified first aid responder on each shift.  90 days |

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

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

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

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

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End of the report.