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

## 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](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: 1 June 2017 End date: 2 June 2017

**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:** 59

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Rannerdale War Veterans' Hospital and Home is owned and operated by the Rannerdale Trust. The service provides hospital, rest home and residential disability (physical) level care for up to 65 residents. On the day of the audit, there were 59 residents.

This surveillance audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board and Ministry of Health. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

This audit has identified that eight of fourteen previous audit findings have been addressed around clinical follow-up of incidents, corrective actions, signing and dating documents, first aid training, chemical storage, medication documentation and competencies, and timeliness of clinical documentation.

Further improvements continue to be required around open disclosure, meeting minutes, staff training, wound documentation, care interventions and self-medication.

This audit also identified an area for improvement around the completion of internal audits and diversional therapy care plans for all residents.

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

There is evidence that residents and family are kept informed. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The quality and risk management programme includes service philosophy, goals and a quality plan. Quality activities are conducted. Intermittent 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 performance appraisal completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is a documented in-service education programme. 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’ records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Residents’ files include three monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and are reviewed at least three monthly by the general practitioner.

An integrated activities programme is implemented that meets the needs of residents. The programme includes community visitors and outings, entertainment and activities that meet the needs of both older and younger residents.

All food and baking is done on site by the contracted catering company. Residents' nutritional needs are identified and documented. Choices are available and are provided.

## Safe and appropriate environment

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

The building has a current warrant of fitness.

## 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. |

Enablers are voluntary and the least restrictive option. There were two hospital residents who required enablers and no residents required the use of restraints during the audit.

## Infection prevention and control

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

The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking.

## 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 | 13 | 0 | 1 | 6 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 3 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has an implemented complaints policy. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. Staff interviewed described the process around reporting complaints. There is a complaint register. Verbal and written complaints are documented.  There were 16 complaints made in 2016 and five complaints received in 2017 year to date. All complaints reviewed document a timely response to complainants. The complaints documentation includes: an investigation, corrective actions when required and resolutions. Additionally, there have been ten complaints (concerns) made in 2017 around food services. Corrective actions are being implemented and are on-going. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Moderate | Seven residents (five rest home and two hospital) 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 alert staff to their responsibility to notify family/next of kin of any accident/incident. The previous finding around informing families remains open. Ten incidents/accidents forms were reviewed for May 2017. 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. One family member (hospital) interviewed confirmed they are notified of any changes in their family member’s health status. |
| 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 (Rannerdale) is owned and operated by the Rannerdale Trust. The service provides hospital, rest home and residential disability (physical) level care for up to 65 residents. At the time of the audit, there were three of fifteen rest home rooms that were not used upstairs due to earthquake risks.  On the day of the audit, there were 59 residents. This includes 34 rest home level residents (including five on long-term chronic care (LTCC) contracts, one resident funded by ACC and one resident on respite) and 25 hospital level residents (including four on LTCC contracts and two residents on acute mental health care contracts). Inclusive in resident numbers, 12 of the residents are on younger persons with disability (YPD) contracts (six at hospital level and six at rest home level). All downstairs rooms (50 rooms) are dual-purpose.  Rannerdale Trust has a strategic plan in place for 2015 – 2020. Strategic goals and objectives are documented and are regularly reviewed by the general manager and the trust board. The organisation has a philosophy of care, which includes a mission statement. Rannerdale War Veterans' Hospital and Home has a business plan for 2016 – 2017 in place.  The general manager is an RN and maintains an annual practicing certificate. He has been at Rannerdale for 14 years. He is supported by a nurse manager (previously in a quality and training role) and a nurse educator. The nurse manager is supported by a clinical coordinator. The general manager and nurse manager have completed in excess of eight hours of professional development in the past 12 months. |
| 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 Moderate | There is an organisational strategic plan that includes quality goals and risk management plans for Rannerdale. Progress with the quality and risk management programme is monitored through monthly quality/management meetings and bi-monthly staff meetings. Interviews with staff confirms that quality data is provided on noticeboards for all staff to read.  The nurse manager coordinates the quality/risk programme and completes clinical assessments with the clinical coordinator. The quality and risk management programme is designed to monitor contractual and standards compliance. Data is collected in relation to a variety of quality activities and an annual internal audit schedule is in place. The internal audit schedule for 2017 to date has been completed and any corrective actions have been followed up and signed off. The previous audit finding around corrective actions has been signed out. Not all meetings and internal audits were evidenced to be held or completed as per schedule.  Residents and relatives are surveyed annually to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Resident meetings and the resident committee meetings are held alternate months. All residents interviewed stated they are aware of the resident committee meetings and how to have input into them or get feedback. This aspect of the previous audit finding has been addressed.  The service has comprehensive policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Policies and procedures are maintained by an external quality advisor who ensures they align with current good practice and meet legislative requirements.  Health and safety policies are implemented and monitored by the three-monthly health and safety meetings. Falls prevention strategies include, residents experiencing frequent falls have an increase in monitoring to anticipate needs, (such as ensuring fluids are at hand, call bells are within reach and falls prevention education for staff).  A health and safety representative (the nurse educator) was interviewed about the health and safety programme. She has completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff. The data is tabled at staff and quality/management meetings. A review of the hazard register indicates that there is resolution of issues identified. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an accidents and incidents reporting policy. The nurse manager or clinical coordinator investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at clinical leadership meetings including actions to minimise recurrence ( link to 1.2.3.6 for meetings) An RN has documented a clinical follow-up of residents in all ten incident forms sampled and demonstrated an investigation of incidents to identify areas to minimise the risk of recurrence. The previous certification audit finding has been addressed. Discussions with the general manager and nurse manager confirms 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. Five staff files were reviewed (one clinical coordinator, one RN, two healthcare assistants (HCA) and one nurse educator). These evidence appropriate employment practices including that reference checks were completed before employment was offered. All staff files sampled have completed current performance appraisals and the clinical component is completed and maintained.  The service has an orientation programme in place that provides new staff with relevant information to meet the needs of the residents under the Aged Residential Care Contract (ARCC). The in-service education programme is being implemented, but not all staff have received the required training. The RNs are able to attend external training, including sessions provided by the local DHB. Registered nurses have attended training around abuse and neglect, wound management and skin integrity/pressure injury care. This aspect of the previous audit finding has been addressed. Night staff have attended training in 2016 and 2017 year to date. This aspect of the previous audit finding has been addressed. There are currently nine RNs working at Rannerdale. Four of nine RNs are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. The general manager and a trust board member interviewed stated that a new organisational structure is in place and that there would be no further changes to the clinical leadership team. There is a full-time nurse manager (RN) and clinical coordinator (RN) who work from Monday to Friday. 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. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes.  The hospital/rest home beds are split into three units, Unit A has 26 residents (7 hospital and 19 rest home). Of the 19 rest home residents in Unit A, 8 are in rooms upstairs (the 8 are mobile and can manage the stairs independently as there is no lift). Unit B has 18 residents (10 hospital and 8 rest home) and unit C has 15 residents (11 hospital and 4 rest home). There are two RNs and one EN on duty on the AM shift, two RNs on the PM shift and one RN on the night shift in the rest home/hospital area. The RNs are supported by adequate numbers of HCAs.  In unit A, there is one HCA on duty on the AM shift, two HCAs on the PM shift and one HCA on the night shift. There are two HCAs on duty on the AM shift, two HCAs on the PM shift and one HCA on the night shift in both units’ B and C. Additionally, there are two HCA floaters on the AM shift available to assist where needed. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Entries are legible, dated and signed by the relevant HCA or RN including designation. The previous certification audit finding has been addressed. There was documented evidence that resident mobility charts have been amended when resident’s care needs have changed. |
| 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 | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. An RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication room is clean and well organised. The medication fridge has temperatures recorded daily and these are within acceptable ranges.  Registered nurses and enrolled nurses responsible for the administering of medications have completed annual medication competencies and annual medication education. Healthcare assistants who act as second checker have also completed medication competencies. This aspect of the previous audit finding has been addressed. Medications were observed to be administered correctly during the audit.  Examination of the medication trolleys (two) evidences that all eye drops are dated on opening. This aspect of the previous audit finding has been addressed.  Twelve electronic medication charts and signing sheets were reviewed (six rest home and six hospital) and identified that; photo identification and allergy status are on all medication charts; indications for use of ‘as required’ medication are documented; all resident medication administration-signing sheets reviewed correspond with the medication chart. Where medications have been discontinued, this is documented and dated on medication charts by the GP; and the GP has documented specific instructions as to what medication and dose were to be given for ‘as required’ medications. These previous audit findings have been addressed.  Three residents were self-administering medications at the time of audit, not all competencies to self-administer medications have been reviewed as per policy. |
| 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 has 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 are 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 the opportunity for resident feedback on the meals and food services generally. Residents and a family member interviewed indicated there has been some dissatisfaction with the food service. The general manager advised that a corrective action plan has been implemented with the contracted meal service provided to address the areas of improvement required from a complaint (link to 1.1.13). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident care plans are resident centred, clear ad easy to understand and document support needs and interventions, however not all care plans have been updated to reflect the resident’s current needs. This previous audit finding has not been addressed. Residents and a family member interviewed confirm they are involved in the development and review of care plans.  Resident care plans are resident centred, clear ad easy to understand and document support needs and interventions, however not all care plans have been updated to reflect the resident’s current needs. This previous audit finding has not been addressed. Residents and a family member interviewed confirm they are involved in the development and review of care plans. |
| 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 in the care planning process.  Dressing supplies are available and a treatment room is stocked for use. Short-term care plans are in use for acute changes in health status and had been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. Short-term care plans are kept in folders at the nurse’s station and are accessible to care staff. This previous audit finding has been addressed.  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 RNs interviewed. Healthcare assistants and RNs interviewed state there is adequate continence and wound care supplies.  Wound assessment, wound management and evaluation forms and short-term care plans are in place for wounds. However, not all wound care documentation was fully completed. This previous audit finding has not been addressed.  On the day of audit there were 12 wounds documented for the rest home and hospital. The wounds include skin tears, chronic ulcers, and surgical wounds and excoriated skin. The wound care nurse specialist had reviewed the chronic wounds and wound care plans reflected the specialist input. There were no pressure injuries.  Monitoring charts were in use; examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required. This previous audit finding has been addressed. |
| 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. | PA Low | The activities coordinator works 30 hours per week Monday – Friday. The activities coordinator has started their Careerforce level four papers. The general manager advised that the service is actively advertising at present for a diversional therapist to join the team.  The service employs two rehabilitation assistants; one works 30 hours and the other 15 hours per week. The service focuses on a restorative model of care.  The integrated programme for rest home and hospital level of care residents takes place in both areas. There is a large recreation room in the facility, which is used by residents and for group activities. There are resources available for care staff to use for one-on-one time with the residents. The needs of younger residents are met.  The service has a van to transport residents to community events and places of interest.  On or soon after admission, a social history which includes previous hobbies, community links, family and interests, is completed and information from this is fed into the diversional therapy care plan and this is reviewed six monthly as part of the care plan review/evaluation. Not all resident files reviewed contain a diversional therapy care plan (link to tracer 1.3.3). There are monthly recreational progress notes in the residents’ file that the activity coordinator completes each month.  Residents praised the activities programme provided. Residents were observed to be provided with and enjoying a wide range of activities on the days of audit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan evaluations are comprehensive, related to each aspect of the care plan and record the degree of achievement of goals and interventions. The interRAI assessments has been utilised in conjunction with the six monthly care plan review. Care plans reviewed had been evaluated within the required timeframes.  There is at least a three-monthly review by the medical practitioner. The family members interviewed confirm they are invited to attend the multidisciplinary care plan reviews and GP visits. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and all chemicals are stored safely. This previous audit finding has been addressed. 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 | A current building warrant of fitness certificate is posted at the entrance to the facility (expiry 1 January 2018). |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has policies and procedures around fire and emergencies. Fire drills have been conducted six monthly. Civil defence and first aid resources were available.  A review of rosters and staff training records/education evidenced that there is a staff member on duty on each shift who has a current first aid certificate. This previous audit finding has been addressed. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections are included on a monthly on-line register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at facility meetings. Benchmarking occurs against other aged care facilities using an on-line programme which has been developed by the external aged care consultant. An outbreak in July 2016 (influenza) was evidenced to have been well managed. |
| 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 two residents with an enabler. Enabler use is voluntary. Staff training records evidence guidance has been given on restraint minimisation and enabler usage. |

# 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 Moderate | The registered nurse (RN) is expected to notify family of incidents as confirmed in policy and by the nurse manager. This had occurred on four of ten incident forms sampled. | Six 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 | Discussions with the management team (general manager, nurse manager and nurse educator) and staff, and review of quality/management and staff meeting minutes demonstrates their involvement in quality and risk activities. Resident meetings and the resident committee meetings are held alternate months. All residents interviewed stated they are aware of the resident committee meetings and how to have input into them or get feedback. This aspect of the previous audit finding has been addressed; however, not all meetings have been completed as per annual meeting calendar schedule. | Not all facility meetings have been completed as per annual meeting calendar schedule. Examples include; four of six scheduled staff meetings for 2016 and one of two staff meetings for 2017 have not been held. For quality meetings; four of five for 2017 have not been held for 2017. Required actions and responsibilities have not been consistently documented, followed up or completed. | Ensure that all facility meetings are completed as per annual meeting calendar schedule and any required actions and responsibilities are followed up and completed.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | Data is collected in relation to a variety of quality activities and an annual internal audit schedule is in place. Audits for 2017 have been completed; however 2016 interval audits have not been completed. Discussions with the new clinical manager identified that they were aware of the 2016 shortfall and have addressed this in 2017 and going forward. | There was no documented evidence of the internal audit calendar schedule being completed for 2016 | Ensure that the annual internal audit calendar schedule is completed  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. While aspects of the previous certification finding has been addressed, a finding around training remains open. | (i) Staff attendance numbers at compulsory trainings have remained low in 2016 and 2017 year to date. For example, seven HCAs attended the cultural safety training, four at the resident rights training and 12 at the skin management and pressure injury training. There was no infection control training provided during that period. (ii) No training has been provided around working with younger residents including around sexuality needs. (iii) Not all staff have attended training. | (i) Ensure staff complete all required training. (ii) Ensure that training is provided around working with younger residents including around sexuality needs. (iii) Ensure that all staff have attended training.  90 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | Competency assessments to self-administer medications are in place for three residents, two evidenced that a review of competency had been completed as per policy. | Competency assessments were in place for three residents (rest home), to self-administer medications however, two competencies have not been reviewed three monthly as per policy. | For those residents who self-administer medications, ensure competency to self-administer medications is reviewed three monthly as per policy.  30 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 have a long-term care plan in place but not all required interventions are documented. Short-term care plans are completed for acute events such as infections. | The following shortfalls were identified in the six care plans reviewed; (i) one rest home resident care plan documents that the resident is independent with care, but the resident’s health status has changed and the care plan has not been updated to reflect the resident’s required assistance with personal hygiene needs. (ii) Two care plans (one YPD rest home and one rest home resident) did not document the management of seizures. (iii) One rest home care plan did not document the management of depression. The same resident was noted to be 11 kgs above target weight range however; the care plan does not identify what interventions are in place to assist the resident to achieve their target weight goal. | Ensure that care plans reflect the resident’s current needs.  60 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 | Short-term care plans are in use for acute changes in health status and had been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. Short-term care plans are kept in folders at the nurse’s station and are accessible to care staff. This previous audit finding has been addressed.  All residents with wounds have a documented wound care assessment and management plan, but there was not individual documentation for every wound. This previous audit finding has not been addressed. Ten of twelve wound care plans were fully completed. | Two of twelve wound care plans reviewed had more than one wound documented on the assessment and management plan. An individual assessment and treatment plan had not been completed for each wound. | Ensure that a wound assessment and treatment plan is completed for each wound.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The activity coordinator develops the monthly activity programme. The service has a focus on a restorative model of care. Two rehabilitation assistants assist with the exercise programmes for individual residents. There are links with the local community. The service has implemented new diversional therapy care plans provided by an external aged care consultant. Diversional therapy care plans were in place in four of six files reviewed. | One YPD rest home file and one hospital resident file reviewed did not have a diversional therapy care plan completed to identify the residents’ recreational goals and interests and the support required to achieve their goals. (The sample of YPD resident files was increased and not all included personalised activity plans.) | Ensure diversional therapy care plans are completed for all residents.  60 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.