# Ripponburn Holdings Limited - Ripponburn Home and Hospital

## 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 Q-Audit 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:** Ripponburn Holdings Limited

**Premises audited:** Ripponburn Home and Hospital

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

**Dates of audit:** Start date: 17 April 2018 End date: 17 April 2018

**Proposed changes to current services (if any):** Reconfiguration of four dual purpose beds approved in March 2017

**Total beds occupied across all premises included in the audit on the first day of the audit:** 36

# 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

Ripponburn Home and Hospital provides residential care for up to 46 residents who require rest home and hospital level care. On the day of the audit there were 36 residents. The facility is operated by Ripponburn Holdings Limited.

This surveillance audit was conducted against a sub set of the Health and Disability Service Standards and the service’s contract with the district health board. The audit process included review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The previously identified area requiring improvement has been addressed. No additional areas requiring improvement were identified during the audit.

## Consumer rights

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

Communication systems were appropriate to the needs of the residents. Sufficient information is made available. Interpreter services can be accessed if required. Interview with residents and family confirmed open communication opportunities with management and staff.

The complaints process is accessible. Records of complaints sampled confirmed appropriate and timely responses. A register is maintained. There have been no complaints to external authorities since the last audit.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The organisation is governed by the trustees. It is a family owned and operated business. The general manager is one of the trustees. The general manager is a registered nurse and is supported by the nurse manager. Both have extensive experience in the aged care sector. Organisational performance is monitored.

The quality and risk management system is fully implemented. Quality data is collated and analysed and the organisation actively seeks opportunities to continually improve their services. Policies and procedures are current. Adverse events are documented, investigated and closed in a timely manner.

Human resources processes ensure suitably qualified staff are on site over the 24-hour period. Competencies are maintained and there are sufficient staff on duty at all times.

## 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. |  | Standards applicable to this service fully attained. |

The registered nurses are responsible for the development of care plans based on a wide range of integrated and detailed clinical information provided by the referrers, residents, staff and family members. Care plans and assessments are individualised, developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medicines are administered by staff with current medication competencies. All medicines are reviewed by the general practitioner (GP) every three months and whenever necessary.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## 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. |

A current building warrant of witness is displayed. There have been no structural alterations to the building since the previous audit.

## 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. |

Restraint minimisation processes are implemented and actively reduce the use of restraints and enablers.

## 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 type of surveillance is appropriate to the size and complexity of the service. The infection rates are discussed in the monthly staff and quality meetings and interventions to reduce infections are also discussed.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

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| **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 management team are responsible for complaint management and there are systems in place to manage this process. The complaints register is maintained. Records of complaints sampled confirmed that complaints are management in line with Right 10 of the Code. Review of quality and staff meeting minutes provided evidence of reporting of complaints to staff, and initiating improvements as required.  Residents and their family are advised on entry of the complaint processes. In interview, residents and family members demonstrated an understanding and awareness of the complaint and feedback process. The copy of the complaints process was readily accessible and displayed.  The GM reported there have been no complaints to external bodies since the last audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents’ records and residents’ and family interviews confirmed effective and timely communication with residents and families. Communication with family members is documented in the family/whanau communication sheets. Residents and family members stated they were kept well informed about any changes to the resident’s status and were advised in a timely manner about any incidents or accidents. The nurse manager advised that families were also routinely advised about the outcome of the regular and urgent medical reviews of the resident. There was also evidence of resident/family input into the care planning process. Examples were also provided where special arrangements and assistance is provided to help aid in communication with residents who have some sensory loss. The nurse manager reported that interpreter services are able to be accessed via the local district health board if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There have been no changes to the governance of the organisation since the last audit. The general manager (GM) is part owner of Ripponburn Home and Hospital along with other family members. The GM is a registered nurse who has extensive experience working in the aged-care sector and has been in their current position for more than 26 years. The GM is supported by an experienced nurse manager (NM) who has been in the position for more than 14 years. The NM is responsible for oversight of clinical care provided to residents and some of the quality activities.  The mission, values and vision remain unchanged. An organisational chart and business plan is documented. The business plan remains current.  The organisation is approved to provide care for up to 46 residents (15 dedicated rest home, four dual purpose and 25 hospital level care beds). The dual purpose were approved by the ministry of health in 2017 and are suitable for residents requiring either rest home or hospital level care. During the day of the audit, there were 11 rest home level residents and 25 hospital residents (two of which were receiving respite services). Resident satisfaction surveys, and interviews with residents and family members, confirmed overall satisfaction with the services provided. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The required policies and procedures are documented. Policies are reviewed as required, remain current and reflect current best practice. A document control system is in place and archived documents are removed from circulation. In interview, staff reported easy access to the documented management system.  There is a quality committee which includes membership from across the organisation. Quality goals are defined and monitored. A range of internal monitoring activities are implemented. These include quality control checks and internal audits. Internal audits are completed by a designated internal auditor. Quality data is collected, collated and analysed to identify trends. Corrective actions are developed and implemented as required. Quality improvement data including: clinical outcomes; adverse events; resident feedback; staffing; health and safety and infection control are discussed during staff and quality team meetings.  Staff feedback and suggestions regarding quality activities are supported and encouraged. This includes a certificate of recognition and achievement for staff whose improvement suggestions are implemented and result in improved services. The organisation is also implementing Te Ara Whakapiri in the event palliative care is needed. Outcomes are being audited regularly in order to seek opportunities for continual improvement.  There is a health and safety, risk management and infection control plan. The NM is a qualified health and safety representative and monitors the health and safety programme. A risk and hazard register includes health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. |
| 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 | Incidents and accidents are documented and managed through the adverse event reporting system. All events are reviewed and collated by the NM. Collated data includes summaries and graphs of various clinical indicators. These are discussed at staff and quality team meetings. Investigations and opportunities for improvement are made (as required). Event documentation sampled and interviews of staff indicated appropriate management of adverse events. Emergency actions were implemented in a timely manner. It was noted that there are currently some residents who fall frequently. In order to prevent this, the organisation’s falls prevention strategies are reviewed and discussed at each quality meeting and staff attend falls prevention workshops for aged residential care through the local primary health network.  The adverse event process is included in the internal audit programme and monitored for effectiveness.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition.  Management representatives interviewed were aware of their essential notification responsibilities. The GM confirmed there has been one essential notification to the Ministry of Health since the last audit. This involved a resident who was admitted to the facility with a pressure injury. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures relating to human resource management are in place. Staff files include job descriptions which outline: accountability; responsibilities and authority; employment agreements; completed orientation; competency assessments and police vetting.  The NM is responsible for managing the in-service education programme. There was evidence indicating that mandatory orientation training is provided and includes: CPR; manual handling; medication competencies; emergency procedures and restraint. Additional in-service education is conducted throughout the year and covers the required topics. Individual records of education are maintained as are competency assessments. Education records for each session and in-service education programmes indicated there is good attendance at education sessions. Care staff are also encouraged to complete a New Zealand Qualification Authority education programme and one of the RNs is the internal assessor for the programme. In interviews, care staff confirmed they have completed orientation, including competency assessments and also confirmed their attendance at on-going in-service education. There are four RN’s who are trained and competent in the use of interRai.  Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one RN and two care staff. The GM and the NM are on-call after hours. Rosters were sampled and confirmed that any temporary gaps in the roster were filled by suitably qualified staff. At the time of the audit there were a number of staff on shortened hours due to lower rest home occupancy. These staff were available to come in at short notice.  Residents and families interviewed reported there was enough staff on duty to provide them or their relative with adequate care. Observations during this audit confirmed adequate staff cover was provided. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system complies with legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. All medications are reviewed as required by the GP. Allergies are clearly indicated, uploaded photos are current and three-monthly reviews are completed.  The medication and associated documentation are stored safely and medication reconciliation is conducted by the RN when a resident is transferred back to service. The service uses pre-packaged packs. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. Controlled drugs are stored securely in accordance with medicine management system requirements. Register is current and correct. Weekly and six-monthly stock checks are conducted.  An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RN was observed administering medication safely and correctly. There were no residents who self-administered medications at the time of the audit. Self-administration policies and procedures are in place if required. |
| 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 | Meal services are prepared on site and served in the allocated dining room. The service employs two cooks and provide meals on wheels to the community. The kitchen was externally audited to ensure they meet the required food safety standards. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place.  The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable potions required by residents and any alternatives are offered as required. The residents’ weights are monitored monthly and supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is completed.  The residents and family interviewed acknowledged satisfaction with the food service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans and resident lifestyle care plans are sufficient to address the residents’ assessed needs and desired goals/outcomes. Any changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the interviewed staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support being received. The previous area requiring improvement had 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. | FA | Activities are appropriate to the needs, age and culture of the residents. The diversional therapist develops an activity planner in consultation with other two activity coordinators. Daily/weekly activities are posted on the notice boards. Residents’ files have a documented activity plan that reflects the resident‘s preferred activities of choice. Over the course of the audit residents were observed being actively involved in a variety of activities. Residents and family/whanau interviewed expressed satisfaction with the activities in place. Individualised activity plans are reviewed six monthly or when there is any significant change in participation.  The activities vary from scrabble, bingo, music, van trips, men’s day out, newspaper reading exercises/walking and church services. There is a programme for the clients in the community once a week at the service. The DT reported that they have combined activities at times with hospital and rest home residents. One on one activities with some residents are conducted. Activities are modified to varying abilities and cognitive impairment. The resident’s activities attendance log is sighted. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ lifestyle care plans and activity plans are evaluated in a comprehensive and timely manner. Reviews are fully documented and include current resident’s status, any changes and achievements towards goals. Family/whanau and staff input is sought in all aspects of care. Short term care plans are developed as per rising need. All care plans and interrail assessments sampled were updated and reviewed every six months or as required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There have been no structural changes to the facility since the last audit. The building warrant of fitness is current. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The have been no changes to the facility since the last audit. The approved fire evacuation plan was sighted. Fire drills are conducted every six months as required. |
| 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 | Surveillance for infection rates is carried out in accordance with agreed objectives and methods in the infection control programme. Surveillance activities are appropriate to the size and setting of the service. Infection rates are monitored, data are collected and analysed. Infection rates are discussed during staff and quality meetings. Specific recommendations to reduce, manage and prevent the spread of infections are discussed in the staff and quality meetings.  The effectiveness of the infection control programme, including surveillance activities was last reviewed in August 2017. The organisation encourages the responsible use of antibiotics by using the McGeer Criteria (which indicates if an infection is present or not) before sending specimens away. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service demonstrated that the use of restraint is actively minimised. There was one resident using a restraint and one resident using an enabler at the time of the audit. The restraint register is current and updated. The policies and procedures have the required definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers. Restraint competencies were last included in the in-service education programme in August 2017. |

# 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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| No data to display |

# 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.