# 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 2018 End date: 3 May 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 52

# 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 certified to provide care across three levels (hospital-medical/geriatric, rest home and residential disability -physical level care). They have a total of 65 beds with current occupancy of 52 residents.

The service is overseen by a general manager, who is well qualified and experienced for the role and is supported by a senior management team, including a resident care manager, business and finance manager, maintenance manager and a learning and development unit manager. Family/whānau and general practitioner interviewed, commented positively on the standard of care and services provided at Rannerdale Veterans Hospital and Home.

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 care planning and care interventions. The service has exceeded expectations around activities.

## 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. |

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents’ rights. Care plans accommodate the choices of residents and/or their family. The complaints policy and procedures are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## 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. |

There is a quality assurance and risk management programme being implemented. Progress with the quality assurance and risk management programme is designed to monitor contractual and standards compliance and to ensure that residents receive care in the best possible way. Quality activities are conducted. Intermittent meetings are held to discuss quality assurance 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 annual in-service education programme in place. 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 provided 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. Resident files included medical notes by the contracted GP and visiting allied health professionals.

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

An activities programme is implemented that meets the needs of the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group.

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

Rannerdale Veterans Hospital and Home has a current building warrant of fitness and there is an approved evacuation scheme. Reactive and preventative maintenance is carried out. Medical equipment has been calibrated. There is a designated laundry and a cleaner’s room with safe storage of cleaning and laundry chemicals. 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 home that include a large lounge and separate dining areas, and smaller seating areas. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines. Staff receive training in first aid and are able to respond to emergency situations. There is a call bell system in all areas. General living areas and resident rooms are appropriately heated and ventilated and have good lighting. 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. |

Enablers are voluntary and the least restrictive option. There are six hospital residents who require enablers and no residents requiring the use of restraints. Staff training records evidence guidance has been given on restraint minimisation and enabler usage. The restraint coordinator is a registered nurse.

## 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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is a registered nurse. There is a suite of infection control policies and guidelines that meet infection control standards. The infection control programme is reviewed annually. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility.

## 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** | 1 | 42 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 1 | 90 | 0 | 1 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Discussions with 13 care staff (five HCAs, five registered nurses (RN), one enrolled nurse (EN) and two recreation programme facilitators) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Nine residents (six rest home including two younger persons with disabilities (YPD), and three hospital including one YPD) and three relatives (one rest home and two hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Written informed consent is gained for general consents and were sighted in the eight resident files sampled. Written consent is also gained for specific procedures such as the influenza vaccine. Resuscitation orders had been signed by the resident and general practitioner in all files reviewed. Residents interviewed confirm they were given good information to be able to make informed choices. Staff interviewed stated the family are involved with the consent of the resident. Enduring power of attorney (EPOA) documents were sighted on the resident's files reviewed. Discussion with family identify the service actively involves them in decisions that affect their relative’s lives.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents’ family/whānau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, going shopping, and attending cafés and restaurants. Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. Rannerdale War Veterans' Hospital and Home has a number of younger people including residents on YPD contracts. These residents are engaged in a range of diverse community activities including (but not limited to) health and wellness, social groups and community outings. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy and procedures are implemented and residents and their family/whānau are provided with information on admission. The residents and families interviewed were aware of the complaints process and to whom they should direct complaints. There are complaint forms available throughout the facility. Staff interviewed described the process around reporting complaints. There is a complaint register. Verbal and written complaints are documented. There were 12 complaints made in 2017 and three complaints received in 2018 year-to-date. All complaints reviewed document a timely response to complainants. The complaints documentation includes an investigation, corrective actions when required and resolutions.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family, or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Monthly resident and resident committee meetings (alternate months) provide the opportunity to raise concerns. An annual resident/relative satisfaction survey is completed. Surveys include young people with disabilities around issues relevant to this group.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education and training on abuse and neglect has been provided in April 2018. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity. There are a variety of resident contracts, however, interviews with residents and relatives and documentation reviewed confirmed that all residents are getting appropriate individualised care despite the mix. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | Rannerdale War Veterans' Hospital and Home has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there was one resident who identified as Māori. A review of the resident’s file identified involvements in specific Māori community events as requested by the resident. Māori consultation is available through the local Nga Hau E Whā National Marae as required. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff job descriptions include responsibilities and staff sign a copy on employment. The staff meeting occurs bi-monthly and includes discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the resident care manager, care coordinator, RNs and HCAs confirmed an awareness of professional boundaries.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The learning & development manager and nurse educator are responsible for coordinating the internal audit programme. A variety of staff meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and also younger people. Staff interviewed stated that they feel supported by the resident care manager, care coordinator and RNs. Care staff complete competencies relevant to their practice.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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 alert staff to their responsibility to notify family/next of kin of any accident/incident. Twelve incidents/accidents forms were reviewed for March 2018. The forms included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Family members interviewed confirmed they are notified of any changes in their family member’s health status.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | 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. At the time of the audit, there were six rest home rooms that were not being utilised upstairs due to earthquake risks. On the day of the audit, there were 52 residents in total. There are 24 rest home level residents (including four on long-term support chronic health condition (LTS-CHC) contracts, four on YPD contracts, one resident on respite care (funded by ACC) and one resident on an individual funding agreement (shared DHB and MoH). Five of the rest home residents are upstairs. There are 28 hospital level residents (including 4 on LTS-CHC contracts and 10 on YPD contracts). All rest home and hospital beds downstairs 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 2017–2018 in place. The general manager reports to the Board of Directors (four board members).The general manager is an RN and maintains an annual practicing certificate. He has been at Rannerdale War Veterans' Hospital and Home for 14 years. The organisation completed an organisational structure change in January 2018. Within the new organisational structure, the general manager is supported by a resident care manager, learning & development manager, home care coordinator, finance & business manager, maintenance manager and an executive administration assistant. The resident care manager is an RN and is supported by a care coordinator. The learning and development manager is an RN supported by a nurse educator. 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 | During a temporary absence, the resident care manager covers the general manager’s role, with the support from the other members of the senior management team.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a quality assurance and risk management programme being implemented. Progress with the quality assurance and risk management programme is designed to monitor contractual and standards compliance and is monitored through the monthly quality improvement/management meeting and bi-monthly staff meetings. The philosophy of the quality assurance & risk management plan is to ensure that residents receive care in the best possible way. Data is collected in relation to a variety of quality activities and an annual internal audit schedule is in place. Interviews with staff confirmed that quality data is provided on noticeboards for all staff to read. Facility meetings have been completed as per the annual meeting calendar schedule. Any required actions and responsibilities are implemented, evaluated and completed. The internal audit schedule for 2018 to date has been completed and any corrective actions have been followed up and signed off. The service has policies/procedures to support service delivery. Policies and procedures are reviewed regularly by an external quality advisor who ensures they align with current good practice and meet legislative requirements. All staff are required to sign the policy and procedure familiarisation form to indicate they have read the policy documents. There are policies and procedures appropriate for service delivery including the specific needs of younger people. There was an annual resident/relative satisfaction survey completed in March 2018 with an 86% overall satisfaction rate. A corrective action plan has been put in place around improvements required with food services. Resident meetings and 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. Health and safety policies are implemented and monitored by the three-monthly health and safety committee meetings. A health and safety representative (maintenance manager) was interviewed about the health and safety programme. The maintenance manager has completed specific 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 the quality improvement/management meeting and staff meetings. A review of the hazard register indicates that there is resolution of issues identified. 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. |
| 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 resident care manager or care 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. An RN has documented a clinical follow-up of residents in the twelve incident forms reviewed and demonstrated an investigation of incidents to identify areas to minimise the risk of recurrence. Discussions with the general manager and resident care manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications required since the last audit. |
| 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 | 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. Nine staff files were reviewed (one resident care manager, one learning & development manager, one care coordinator, two RNs, three HCAs and one recreation programme facilitator). These evidence appropriate employment practices including that reference checks were completed before employment was offered. All senior management (including the general manager) had position description reviews completed during the organisational structure change.The service has an orientation programme in place that provides new staff with relevant information to meet the needs of the residents. The residential care manager was employed in January 2018 and completed a comprehensive orientation process. The dedicated learning & development unit was established to support staff training and development. The in-service education programme for 2018 is being implemented and the education programme for 2017 has been completed. The RNs are able to attend external training, including sessions provided by the local DHB. There are currently eight RNs working at Rannerdale War Veterans' Hospital and Home and all eight are interRAI trained. Staff training has included sessions on privacy/dignity, spirituality/counselling and social media to ensure the needs of younger residents are met.  |
| 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. Staff ratio mix was reviewed during the organisational structure change to reflect the needs of the residents. A senior nursing team is in place, there is a full-time resident care manager and care coordinator who work from Monday to Friday. There is always a senior RN and senior HCA on duty 24/7. There is a long standing consistent HCA team available. A member of the management team is on call at all times. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents.The hospital/rest home dual-purpose beds are split into seven wings (Shirley Symons, Jacinda Baker, John Masters, Totara, Rimu, Kowhai and Manuka wings). At the time of the audit there were 24 rest home residents in total. Of the 24 rest home residents, five are in rooms upstairs in the Rata wing (all five residents are mobile and can manage the stairs independently, there is also a lift available should the residents prefer to utilise it). In the hospital/rest home area there are two RNs and one EN on duty on the morning shift, two RNs on the afternoon shift and one RN on the night shift in the rest home/hospital area. The RNs are supported by adequate numbers of HCAs. There are six HCAs on duty on the morning shift, five HCAs on the afternoon shift and three HCAs on the night shift. One of the HCAs on the morning shift that covers the rest home residents in the upstairs Rata wing. Residents who require one-on-one supervision are supervised by non-clinical support workers as per their specific contractual requirements and/or service plans.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were legible and where necessary, signed (and dated) by a RN. Entries are legible, dated and signed by the relevant HCA or RN including designation. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.  |
| 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 eight files reviewed. A registered nurse completed an initial assessment on admission. The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. 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 | Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. RNs interviewed, stated residents discharged home under the restorative care model have a documented discharge plan ensuring ongoing community support. The residents and their families are involved for all exit or discharges to and from the service. The service uses the yellow envelope transfer form for acute transfers to hospital. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs, enrolled nurse and senior caregivers who administer medications complete annual medication education, training and competency assessment. Annual in-service education on medication is provided by the supplying pharmacist. Medications (robotics packs) are checked on delivery against the electronic medication chart and any discrepancies feedback to the pharmacy. All medications are stored safely in the central medication room. Standing orders are not used. Two self-medicating residents had a self-medication competency completed and reviewed three monthly by the GP. The medication fridge is monitored daily. Syringe driver competencies have been completed by RNs and syringe drivers have been calibrated. All eye drops were dated on opening. Sixteen electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed ‘as required’ medications include the indication for use. The dose and time given is signed for on the administration sighing sheet. Pain monitoring forms record the effectiveness of pain relief.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA 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. The site manager oversees the nutritional service with the assistance of a full time cook and catering assistants. There is a four-weekly winter and summer menu, which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen. There is a registered food control plan implemented. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. The kitchen is adjacent to the large dining room. 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. 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 (link 1.3.5.2). 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 | Rannerdale records the reason for declining entry to potential residents should this occur and communicates this to potential residents/family/whānau and refers them back to the referral agency. The reason for declining entry would be if there were no beds available or the service could not meet the assessed level of care.  |
| 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. InterRAI assessments and where applicable paper assessments are reviewed at least six monthly for all residents. The YPD and LTS-CHC files reviewed had a suite of paper assessments that linked to resident goals/objectives. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The interRAI and other clinical nursing assessments inform the development of the resident’s care plan. The long-term care plans reviewed described aspects of support required to meet the resident’s goals and needs, however not all residents care needs had care plan interventions noted in sufficient detail to guide the care staff. The care plans sampled identified allied health involvement. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the care plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. Not all required monitoring was completed as noted in the care plan. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident’s health status. Resident files reviewed included communication with family recorded.Wound assessment and wound management plans were in place for twenty wounds (13 residents); 12 skin tears, one surgical wound, one chronic ulcer, two stage one pressure injuries and four skin lesions. All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing with the exception of the chronic ulcer. Staff report there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Short-term care plans were also in place for two residents with stage one pressure injuries. The RN interviewed could describe the referral process to a wound specialist or continence nurse. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | CI | The activities staff at Rannerdale provide an activities programme encompassing links to the restorative model of care and enabling strong community links for the residents. The joint hospital and rest home programme is scheduled across six days. A monthly activities calendar and newsletter is distributed to residents and is posted on noticeboards. Group activities are voluntary and developed by the activities staff in consultation with the occupational therapist, physiotherapist and rehabilitation assistants. Residents are able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. The service has a van which is used for resident outings. Trips in the community have included (but not limited to) visits to other facilities for competitions, to the museum, parks, gardens and a local swimming pool games. On-site activities include board games, canine therapy visits, bowls, indoor games, happy hour, gym circuit sessions, exercises, brain gym and church services. Activities for younger people include breakfast club, coffee outings, walks and one-on-one talks. Special interest groups include a creativity group, a Friday lunch club where themes are celebrated as per participants requests and with input from the creativity group, a well-being group and a pilot creative art group for veterans with post-traumatic stress disorders. The activities programme has exceeded the required standard.The diversional therapist is involved in the admission process completing the initial profile, an activities care plan, and a 24-hour activities plan. An activities plan is completed within timeframes, a monthly record of attendance to activities and a review is maintained and evaluations are completed six-monthly. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept ensuring all such residents are included. Activities are varied to meet the needs of the various categories of residents at the service. Residents interviewed spoke positively of the activity programme with feedback and suggestions for activities made via monthly meetings and surveys. The organisation has an occupational therapist that oversees the activity programme, is available for activity staff to discuss recreational programmes and provides education for activity staff twice a year. Residents funded through the MOH disability contract have extra support to assist them to connect to the community. Residents interviewed confirmed that they are assisted to access outside interests. Residents were observed participating in activities on the days of audit.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six monthly in seven of eight resident files reviewed. One resident had not been at the service six months. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals, however care plans had not always been updated following a change in health status (link 1.3.5.2). Ongoing nursing evaluations occur as indicated and are documented within the progress notes.  |
| 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 occurs, referral documentation is maintained. Residents and/or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance. Documentation reviewed included referrals to Diabetic nurse specialist, wound nurse specialist, mental health and hospital specialist.  |
| 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 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. The service is divided into eight wings named after NZ icons including well known military personnel. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade is provided. The facility has a designated resident smoking area away from the buildings. Health care 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 FacilitiesConsumers 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. Health care assistants interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is one large lounge with seating arranged to allow residents to mobilise freely and a conservatory adjacent to this. There are smaller lounges for residents and families around the facility. There is a large dining area for the residents. All areas are easily accessible for the residents. 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 ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. Manufacturer’s data safety charts are available. All linen and personal clothing is laundered on-site. There is a well-equipped laundry with a defined clean/dirty area where all linen and personal clothing is laundered by designated laundry staff. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. There are dedicated cleaners to carry out cleaning duties throughout Rannerdale. Cleaning trolleys are stored safely when not in use. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.  |
| 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 an emergency/disaster procedures manual in place. There is a recently approved updated fire evacuation scheme. There is a staff member with a current first aid certificate on duty 24/7. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 30 January 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored for emergency use and alternative heating and cooking facilities (three BBQ and gas bottles) are available. There is a generator available if there is a power failure. Emergency lighting is installed. There is an effective call bell system in place. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff.  |
| 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 | Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control managementThere 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 established 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. It is linked into the quality improvement system and the facilities results are benchmarked against the results of other organisations utilising the system, Monthly infection control reports are generated, and graphed results displayed on staff noticeboards. The care coordinator is the designated infection control nurse. The infection control team includes members of the management team and staff representatives from each department. Minutes of the infection control and prevention committee meetings are available for staff. Infection control and prevention audits have been conducted and include hand hygiene and infection control practices. The results of infection control and prevention audits are reported to the ICP committee, the management team and staff through meetings and noticeboard communication. ICP and Hand Hygiene Education is provided for all new staff on orientation. The infection control annual programme review, last occurred in March 2018.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The care coordinator 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 the community infection prevention and control nurse specialist at the DHB. The infection control team is representative of the facility. 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 proceduresDocumented 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. 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. Resident education is expected to occur as part of providing daily cares.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Systems in place are appropriate to the size and complexity of the facility. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified, and quality initiatives are discussed at staff meetings (minutes sighted). Benchmarking occurs against similar facilities through Healthcare compliance solutions. The GP reviews antibiotic use at least three monthly with the medication review. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisationServices 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 six residents using seven enablers (two bed rails and five lap belts). Enabler use is voluntary. Four resident files using enablers were reviewed, three of four had monitoring completed within the required timeframes (link 1.3.6.1). The care coordinator is the restraint coordinator. Staff training records evidence that 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 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The registered nurses’ complete assessments to identify the care needs of the resident and use this information to inform the development of the care plan. Not all care plan interventions for current assessed care needs were documented in the LTCPs in sufficient detail to guide the care staff. Care plans were consistently reviewed with health changes and routine evaluations and the changes were documented in the evaluation section, however care plans were not always updated. There was evidence of the use of short-term care plans, and these were signed out or added to the long-term care plan evaluation section, if not resolved.  | Shortfalls were identified around care plan interventions in six of the nine care plans reviewed. i) One rest home resident did not have dietitian instructions updated in the care plan regarding nutritional supplements and monitoring of food and fluid. However, staff were implementing the nutritional supplements and weekly food and fluid monitoring had been commenced as per dietitian instructions, the same resident had changes in health status around continence, mobility and activities of daily which were documented in the evaluation section but interventions in the care plan not updated.ii) One rest home level care resident did not have care plan interventions documented or documented in sufficient detail, to guide the care staff in the management of chest pain, behaviour and reporting of speech language therapy monitoring requirements. iii) One ACC respite resident on warfarin did not have associated risks documented. The same resident had made significant improvement in mobility and communication, but the care plan had not been updated. Turning charts were evident, but care plan evaluations stated these had been discontinued. iv) Two Insulin dependent hospital residents’ care plans (including the YPD resident) had no information around acceptable BGL ranges and recognition and treatment of hypoglycaemia and/or hyperglycaemia. v) The interventions for one hospital resident with marked improvement in mobility and nutritional status had not been updated in the care plan but were documented in the evaluation.  | (i)-(v)Ensure that care plan interventions reflect the resident’s current need and that there is sufficient detail to guide care staff.60 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Required monitoring is documented in care plans but evidence of implementation was not consistent. Short-term care plans are completed. Residents on enablers include all required assessments, however monitoring was not always completed as per care plan instructions.  | One resident using bed rails as an enabler required two hourly monitoring did not evidence this was completed.  |  Ensure that monitoring of enablers is documented as occurring as directed. 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The activities team in association with management have established several groups to meet specific resident needs, which were previously not addressed in the activities programme. These groups include a pilot programme for residents with post-traumatic stress disorder where residents are encouraged to initiate and explore art therapy, a well-being group, a creativity group and a lunch club. Each of these groups has been implemented to meet specific identified needs.  | In late 2016/early 2017, the activities team rearranged the activities programme from a 'one size fits all' to include smaller groups that meet the needs of specific groups of residents. As there are a significant number of war veterans in the home, the activities team in association with management, decided to pilot a closed art therapy group for residents with post traumatic stress disorder (PTSD). The pilot has now finished, and results include increased social engagement and cohesiveness within the group and a noticeable improvement in mood levels. The group have decided to continue meeting and supporting each other. The evaluation of this pilot programme has positive implications for the larger scale implementation of arts therapy for veterans and other residential care communities with a prevalence of PTSD in NZ. Additional small groups that have resulted in increased satisfaction and a sense of better use of existing skills of residents have included a well-being group, a Friday lunch club and a creativity group.The combined implementation of the each of the above groups has impacted positively on residents lives and evidenced in resident discussions, meeting minutes and the latest survey results.  |

End of the report.