

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

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Rannerdale War Veterans Home Limited
Premises audited:	Rannerdale War Veterans' Hospital and Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 1 November 2019 End date: 1 November 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	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

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

General overview of the audit

Rannerdale War Veterans' Hospital and Home is certified to provide care across three levels of care; hospital-medical/geriatric, rest home and residential disability – physical. There are a total of 65 beds with current occupancy of 52 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

The service is overseen by a chief executive officer and clinical manager who are qualified and experienced for the roles. They are supported by a stable team of registered nurses and care staff. Residents and family/whānau and the general practitioner commented positively on the standard of care and services provided at Rannerdale Veterans Hospital and Home.

Two of two previous findings from the certification audit around care planning and monitoring have been addressed.

The service has continued to maintain a continuous improvement rating around activities.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

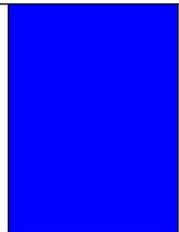
Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a business plan with goals for the service that has been regularly reviewed. The service has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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.		All standards applicable to this service fully attained with some standards exceeded.
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Residents' records reviewed provided evidence that the registered nurses' complete clinical assessments, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family and allied health professionals involved in the care of the resident. Care plans demonstrated 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 resident groups. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each resident group including younger people.

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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Rannerdale Veterans Hospital and Home has a current building warrant of fitness. Reactive and preventative maintenance is carried out.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Enablers are voluntary and the least restrictive option. There are eleven residents who require enablers and no residents requiring the use of restraints. Staff training records evidenced guidance has been given on restraint minimisation and enabler usage. The restraint coordinator is a registered nurse.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	16	0	0	0	0	0
Criteria	1	42	0	0	0	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>All complaints are logged onto the electronic register. There were 39 complaints logged for 2018. Discussion with the manager and review of 2018 complaints evidenced that many were incidents. All complaints (whether an incident or a complaint) for 2018 had been followed up with the complainant, any issues actioned closed off. There were three complaints year to date for 2019. One was around the standard of care, one around a resident and smoking and one resident complaining about another. All three had been investigated and closed off to the satisfaction of the complainant. Staff meetings and the quality meeting documented that complaints had been discussed with staff.</p> <p>Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>A policy is in place based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The chief executive officer (CEO), clinical manager, five registered nurses and one enrolled nurse interviewed understood about open disclosure and providing</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>appropriate information when required.</p> <p>Residents interviewed (three hospital level, including one younger person and three rest home level including one respite) stated they were welcomed on entry and given time and explanation about the services and procedures.</p> <p>Eight incidents/accidents forms were reviewed for October 2019. 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 (two rest home level including the younger person's relative and the respite person's relative and one hospital level) confirmed they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>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. There are 50 dual purpose beds downstairs and there are 15 beds upstairs (three of eight dual purpose rooms closed for renovations).</p> <p>On the day of the audit, there were 52 residents in total. There were 27 rest home level residents, including seven on long-term support chronic health condition (LTS-CHC) contracts, there were also four rest home level respite residents. There were 25 hospital level residents including; four LTS-CHC contracts, one ACC, one end of life and one individual funding through the DHB. There are seven dedicated rest home beds.</p> <p>Rannerdale Trust has a strategic plan in place for 2015–2020. Strategic goals and objectives are documented and are regularly reviewed by the CEO 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 2018–2020 in place. The CEO reports to the Board of Directors (four board members).</p> <p>The CEO is an RN and maintains an annual practicing certificate. She has been in the role since 2018 having been in a variety of roles at Rannerdale prior to this role including the general manager role. The CEO is supported in her role by an experienced registered nurse clinical manager, a business manager, a nurse educator and also non-clinical managers. Staff interviewed stated they feel very well supported by the management team.</p> <p>The CEO and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>A quality and risk management system is understood and being implemented as confirmed through a review of documented meetings and during interviews with the management and staff.</p> <p>Policies and procedures have been developed by an external consultant and align with current good practice and</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>meet legislative requirements. Policies have been reviewed, modified (where appropriate) and implemented. New policies are discussed with staff.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Quality data and outcomes are discussed with staff in the quarterly staff meetings, quarterly quality meetings and monthly RN meetings. Additional meetings include; monthly falls minimisation meetings and complex care meetings (where the team review the care needs for the more complex residents). Meetings document that corrective actions are discussed and followed up/signed off at relevant meetings.</p> <p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Interviews were conducted with the health and safety officer who is the maintenance manager. Staff health and safety training begins during their induction to the service. Health and safety is a regular topic covered in the staff and quality meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, intentional rounding with two-hourly checks, and challenging behaviour plans.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality and staff meetings including actions to minimise recurrence. Monthly results are posted up on staff noticeboards.</p> <p>An RN has documented a clinical follow-up of residents in all eight incident forms reviewed and demonstrated an investigation of incidents to identify areas to minimise the risk of recurrence. Discussions with the CEO and clinical 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 and no infection outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>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. Seven staff files were reviewed (two registered nurses, four HCAs and one recreation programme facilitator). These evidenced appropriate employment practices including</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>that reference checks were completed before employment was offered.</p> <p>The service has an orientation programme in place that provides new staff with relevant information to meet the needs of the residents.</p> <p>There is a very comprehensive in-service education programme has been developed and is supported by the nurse educator. The training programme for 2019 is being implemented and the education. Training is provided in study blocks for staff over the year as well as additional training as needed. Attendance rates were very high (100%). The RNs are able to attend external training, including sessions provided by the local DHB. Subjects have included syringe driver, palliative care, infection control and wound care. There are currently nine RNs working at Rannerdale War Veterans' Hospital and Home and all nine are interRAI trained. Four of the RNs have achieved proficient level PDRP.</p> <p>Staff training has included sessions on privacy/dignity, spirituality/counselling and social media to ensure the needs of younger residents are met.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery.</p> <p>A senior nursing team is in place, there is a full-time CEO and clinical manager 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 identified that staffing is adequate to meet the needs of residents.</p> <p>The hospital/rest home dual-purpose beds are split between seven wings (Shirley Symons, Jacinda Baker, John Masters, Totara, Rimu, Kowhai and Manuka wings). At the time of the audit, there were 27 rest home residents and 25 hospital residents in total.</p> <p>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. 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 two - three HCAs on the night shift (as influenced by the units acuity and occupancy).</p> <p>An additional HCA is rostered on the morning shift to support the rest home residents in the upstairs Rata wing if needed. Residents who require one-on-one supervision are supervised by non-clinical support workers as per their specific contractual requirements and/or service plans.</p>
<p>Standard 1.3.12:</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet the MOH guidelines. The RNs, enrolled nurse and senior caregivers who administer medications complete annual competency</p>

<p>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>assessments. Annual in-service education on medication is provided. Syringe driver competencies have been completed by RNs. Medications (blister packs) are checked on delivery against the electronic medication chart (and checked in) and any discrepancies feedback to the pharmacy. All medications are stored safely in the one medication room. Standing orders are not used. A record of hospital stock and expiry dates is maintained. Four rest home self-medicating residents (inhalers/eye drops) had a self-medication competency completed and reviewed three monthly by the GP. The medication fridge is monitored daily. All eye drops were dated on opening.</p> <p>Twelve electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviewed the medication charts at least three monthly. Prescribed 'as required' medications included the indication for use and the effectiveness was recorded in the electronic system and progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The contracted meal service provider prepares and cooks all meals on-site. The site kitchen manager (also cooks four days a week) oversees the nutritional service with the assistance of cooks and morning and afternoon kitchenhands. The food control plan was issued April 2019 valid until November 2019 pending the installation of a new overhead canopy which had been completed. A verification visit has been scheduled. Food services staff are trained in safe food handling and food safety procedures.</p> <p>There is a four-weekly seasonal winter and summer menu, which had been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen. The kitchen is adjacent to the large dining room. The meals are served from the bain marie in the kitchen to residents in the large dining room. A bain marie has been purchased for the serving of meals in the hospital dining rooms. Meal temperatures are checked during service in both dining rooms. The cook and kitchenhand serve meals. The kitchen manager receives resident dietary profiles and is notified of any dietary changes. Modified texture diets and resident dislikes and food allergies are accommodated.</p> <p>A daily food control plan is followed with daily fridge, freezer, inward chilled goods and end-cooked temperatures taken and recorded. All food is stored correctly and date-labelled in fridges, freezers and the pantry. There is a cook and kitchenhand cleaning schedule maintained.</p> <p>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.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused,</p>	<p>FA</p>	<p>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. The respite care resident and EOL resident were not required to have long-term care plans. The care plans included documented interventions in sufficient detail to guide the care staff in the safe delivery of care. Care</p>

<p>integrated, and promote continuity of service delivery.</p>		<p>plans were individualised, and resident centred. Care plans reviewed had been updated with any changes to health. The previous finding around care plans has been addressed.</p> <p>The care plans reviewed identified allied health involvement in the care and wellbeing of the resident. There was evidence the resident and their family/whānau were involved in the care planning. Care plans are completed on the electronic resident management system, printed off and readily available to care staff. Staff interviewed reported they found the care plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is documented evidence that the relatives have been notified regarding any changes to health including accident/incidents, infections, GP visits, medication changes, appointments and referrals.</p> <p>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. Electronic resident files reviewed included a record of communication with family.</p> <p>Wound assessment and wound management plans were in place for three wounds including one chronic leg ulcer, one surgical wound and one facility acquired stage two pressure injury (hospital resident). Photos demonstrated the healing or non-healing process. The chronic wound is linked to the long-term care plans. Short-term care plans were in place for wounds. Five RNs and one enrolled nurse interviewed confirmed there is wound care and advice readily available through the wound nurse specialist at Nurse Maude.</p> <p>Staff reported there are adequate continence supplies and dressing supplies.</p> <p>Monitoring forms are utilised to monitor a residents' progress such as bowel monitoring, behaviour charts, weekly weighs, blood sugar levels, blood pressure monitoring, pain assessments, food and fluid monitoring, two hourly turn charts, daily exercise charts and enabler monitoring. Enabler monitoring was in place for 11 residents on enablers. The previous finding around enabler monitoring has been assessed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and</p>	<p>CI</p>	<p>A recreational programme manager who is progressing through diversional therapy papers, works 30 hours a week and oversees the activity team, documentation and spends one on one time with residents. There are three other activities staff who work Monday to Friday. There are eleven volunteers with four involved in canine friend visits four times a week, one on one activities with residents and the programme on Saturdays is led by volunteers.</p> <p>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. There is an integrated rest home/hospital programme scheduled across six days. A monthly activities calendar is distributed to residents and is posted on</p>

<p>the setting of the service.</p>		<p>noticeboards. Group activities are voluntary and developed by the activities staff in consultation with the occupational therapist, physiotherapist and rehabilitation assistants (employed). Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. A number of clubs and groups have been initiated by residents including the younger people. Existing groups since the last audit have developed in interest and there have been more groups initiated as a result of resident interests and suggestions. Some groups are resident led.</p> <p>On-site activities include board games, bowls, indoor games, exercises, quizzes, brain gym, walking groups, weekly entertainment, movie time, reminiscing, social gatherings and church services. Activities for younger people include gym circuit sessions, breakfast club, coffee outings, playing pool, walks, one-on-one talks and visits into the community. Special interest groups include a creativity group, a wellbeing group and art group. A younger person has art displayed at the local library which interests other residents to visit the library. Younger people are supported to access community groups/events of their interest. A community access group spend one-on-one time with residents promoting their independence such as how to catch a bus, going with them on the bus to their destination and ensuring they feel comfortable and safe.</p> <p>The recreational programme manager completes an initial assessment and resident profile, an activity care plan, and a 24-hour activities plan. Evaluations are completed six-monthly as part of the multidisciplinary team review and complex team meetings. Activities are varied to meet the needs of the groups of residents at the service. The service has a van which is used for resident outings and trips into the community.</p> <p>Residents and relatives interviewed spoke positively of the activity programme with feedback and suggestions for activities made via monthly meetings and surveys.</p> <p>Residents were observed participating in activities on the days of audit. Residents funded through the MOH disability contract have extra support to assist them to connect to the community.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>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 six of eight resident files reviewed, (sample size was extended to two long-term residents under the ARC).</p> <p>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 and resolved or if an ongoing problem this was added to the long-term care plan. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness. Regular and reactive maintenance occurs. Medical equipment and electrical appliances have been tested and tagged and calibrated. Hot water temperatures are checked regularly and are maintained below 45 degrees Celsius.</p> <p>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.</p> <p>Healthcare assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraint and eleven residents with enablers (bed rails and/or lap belts). Enabler use is voluntary. Two resident files using enablers were reviewed, all had monitoring completed within the required timeframes. The clinical coordinator is the restraint coordinator. Staff training records evidenced that guidance had been given on restraint minimisation and enabler usage.</p>

Specific results for criterion where corrective actions are required

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

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

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

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The activities team in association with management, established several groups to meet specific resident needs. These groups have gone on evolve further and gather more interest. There have been new resident-initiated groups since the last audit. The service has maintained the continuous</p>	<p>The activities team have continued to include smaller groups in the activity plan that meets the needs of specific groups of residents. Previous groups such as the art therapy group for residents with post-traumatic stress disorder (PTSD) has continued with a positive effect on social engagement and cohesiveness. The lunch group has now become a “pop up” restaurant with themes and the group choice of meal which is now served in the “pop up” restaurant and to the residents in the dining room if they wish, who do not attend the “pop up” restaurant. The happy hour has now become a social gathering with resident led activities. A group of younger people initiated a baking group with choices on the baking theme that was shared with other residents and staff such as Halloween biscuits. Feedback on the baking to the group improved their sense of wellbeing. The mindfulness group has been beneficial for residents who choose their topic of discussion. New groups also include the drama group and fall prevention group. The falls prevention group are residents who have been identified (in consultation with the clinical manager and physiotherapist) as high or moderate risk of falls. The service introduced the falls prevention group which focused on education, strength, balance and exercise. The falls prevention group is held weekly. There are also other exercise related activities in the programme that the residents can attend including circuit class, walking groups, sit and dance exercises, exercise class and circle bowls. Since the introduction of the falls prevention group in</p>

		<p>improvement rating around meeting the recreational needs of all the resident groups.</p>	<p>July 2019 there has been a downward trend in falls from 34 in August to 22 in October.</p> <p>Each of these groups has been implemented to meet specific identified needs. The combined implementation of each of the above groups has impacted positively on residents' lives and evidenced in resident discussions, meeting minutes, review of the activity programme and the latest survey results.</p>
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End of the report.