# Rannerdale Village 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 BSI Group New Zealand Ltd, 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 Village 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: 15 April 2021 End date: 16 April 2021

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

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

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Rannerdale War Veterans Care has been renamed Rannerdale Village and is owned by a charitable trust. The service is certified for hospital services (hospital and medical); rest home care and residential disability services - physical. They have a total of 62 beds with current occupancy of 49 residents.

This certification audit was conducted against the relevant Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

The service is managed by the clinical manager/registered nurse who is also the acting CEO. She is responsible for the daily operations of the service. The clinical manager is supported by a quality coordinator, a learning and development manager and a stable workforce.

The residents and relatives spoke positively about the care provided.

There were no areas identified for improvement. The service has exceeded expectations 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. |

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. Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family stated they are kept well informed on their relative’s health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

## 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. |

Rannerdale Village implements an on-line quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety, including hazards. The service meetings include discussion around quality data. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times. An implemented orientation programme provides new staff with relevant information for safe work practice. The education programme includes mandatory training requirements including supporting younger people with a disability and additional in-service including medical conditions.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

The service has assessment processes and residents’ needs are assessed prior to entry. There is an admission pack available for residents and families/whānau at entry. Assessments, residents care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in care. The activities assistant implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents. There are medication management policies in place that meet the legislative requirements. Staff responsible for administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by a general practitioner. All food and baking is done on site. Resident`s individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## 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. |

There is an emergency management plan to guide staff in managing emergencies and disasters. Six monthly fire drills occur. Civil defence supplies are in place. There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current building warrant of fitness. Resident rooms and bathrooms are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Communal areas within the facility are easily accessible. The outdoor areas are safe, accessible and provide seating and shade. There is one person on duty at all times with a current first aid certificate. Housekeeping/laundry staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. The laundry is done on site.

## 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. |

There are policies and procedures on safe restraint use and enablers. There are eight residents voluntarily using enablers and one resident with an emergency restraint. A registered nurse is the restraint coordinator. Resident files included assessments, consents and care plans appropriate to the identified risk and care needed for enablers and restraint. Evaluations and reviews assessing the continued need for restraint were documented. Staff receive training around restraint and challenging behaviours.

## 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/registered nurse is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Seven residents (five hospital, including one younger person with disabilities (YPD), one ACC respite, one long term chronic health (LTS-CHC) and one end of life) and two rest home level including one YPD) and three relatives (two hospital level, including the family of a younger person and one rest home) interviewed, confirmed that information has been provided around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Discussions with nine care staff (four HCAs, three registered nurses (RN), one enrolled nurse (EN) and one activities assistant) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes were discussed with residents and families on admission. Written general consents were signed as part of the admission agreement. Specific consent had been signed by resident/relatives for procedures such as the influenza vaccine. Discussions with registered nurses confirmed that staff understand the importance of obtaining informed consent for providing personal care and accessing residents’ rooms.  Enduring power of attorney (EPOA) evidence is filed in the residents’ electronic charts and activated where required.  Advance directives for health care including resuscitation status had been completed where residents were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision in consultation with family/whanau. Resident files show evidence that where appropriate the service actively involve family/whanau in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance.  Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Rannerdale Village has developed a close relationship with children, parents and teachers from a neighbouring school. Community groups visit the home as part of the activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal, email and written on the complaints form is maintained by the clinical manager/acting CEO using an online complaints’ register. There were ten complaints for 2020 including one via the CDHB and seven complaints (year to date) for 2021 including one via the Health and Disability Commissioner. All complaints/concerns have been managed in line with Right 10 of the Code.  A review of complaints documentation evidenced resolution of the complaint, to the satisfaction of the complainant and all complaints have been discussed in monthly quality and management meetings, monthly staff and clinical meetings.  Residents and family members advised that they are aware of the complaint’s procedure.  The complaint via the DHB was investigated and unsubstantiated. The complaint via the Health and Disability Commissioner has been responded to by the service and is currently with the Health and Disability Commissioner. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service has available information on The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) at the main entrance to the facility. The code of rights is also displayed in the resident areas. The welcome information includes about the code of rights. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission, with the clinical manager. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. Bi-monthly resident meetings 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 Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. House rules and a code of conduct are signed by staff at commencement of employment. Care staff interviewed stated they promote independence with daily activities where appropriate. Resident’s cultural, social, religious and spiritual beliefs are identified on admission and they are included in the resident’s care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The Māori health plan identifies the importance of whānau. There was one resident who identified as Māori at the time of audit. 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 and through the national defence Force’s Māori cultural advisor as required. The clinical manager, registered nurses and care staff were able to describe how to access information and provide culturally safe care for Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six- monthly to ensure the clients individual culture, values and beliefs are being met. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services, and they are supported to attend other community groups as desired. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process meets best practice in regard to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Healthcare assistants interviewed could describe how they build a supportive relationship with each resident and stated that their open and family-like approach to care and support assists residents and their families to be able to treat the service like home. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The Clinical Manager/acting CEO and team at Rannerdale Village are committed to providing service of a high standard, based on the mission statement and philosophy. This was observed during the day with the staff demonstrating a caring and respectful attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures developed by an external consultant that provide a good level of assurance that it is adhering to relevant standards. Care staff and RNs have access to internal and external education opportunities. Staff have a sound understanding of principles of aged care and care of the younger person and stated that they feel well supported by current management. Regular facility and clinical meetings, and shift handovers enhance communication between the teams and provided consistency of care.  The clinical manager/acting CEO has implemented a series of improvements including increased community involvement and improvements around manual handling, resident mobility and improved reporting of trends. The service is focusing on strengthening relationships with ex-service people including fire, police and ambulance services and creating an improved cohesive working relationship with the board trust and veteran services. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The clinical manager/acting CEO promotes an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings (open to family) and annual surveys. An elected resident representative prepares a report for the boards review. Areas for improvement are discussed at resident meetings (sighted in minutes) and are available in a meeting minutes folder available in the main lounge.  Accident/incident forms for falls showed relatives had been informed of the incident. Relatives interviewed stated they are notified promptly of any changes to residents’ health status.  Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Rannerdale Village is owned and operated by the Rannerdale Trust. The service provides hospital, rest home and residential disability (physical) level care for up to 62 residents. At the time of the audit, there were six rest home rooms that were not being utilised upstairs due to earthquake risks. There are two rooms unavailable pending renovations.  Fourty-seven beds are dual-purpose. On the day of audit there were 49 residents in total. There are 14 rest home residents, including five on long term chronic health (LTS-CHC) agreements, one on an ACC contract and two on younger persons disabled (YPD). There were also 35 hospital residents including 11 younger persons disabled, four on LTS-CHC contracts, one on an ACC respite contract and two residents on end-of-life contracts. All other residents were under the ARCC.  The facility is managed by an experienced and suitably qualified clinical manager/acting CEO who is a registered nurse (RN) and has been in this position for three months. The clinical manager was employed six months prior to her appointment as acting CEO. The manager is supported by a quality coordinator, a learning and development manager, registered nurses and long serving care staff. The clinical manager/acting CEO is responsible for oversight of the clinical service in the facility and reports monthly to the board of directors (four members). The clinical manager/acting CEO has access at any time to the board chair and maintains regular contact via phone and email.  There is a documented five-year strategic plan (2021 to 2026) which has been recently accepted by board and the trust. The strategic plan includes a focus on strengthening relations with the service community and providing a fit for purpose facility for changing generations. Goals and objectives are reviewed at monthly board meetings.  The clinical manager/acting CEO maintains an annual practicing certificate and has maintained at least eight hours annually of professional development that is related to managing a rest home and hospital including attending DHB forums and aged care forum and conference. |
| 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 the temporary absence of the clinical manager/acting CEO the learning and development manager provides clinical and management oversight of the facility including the on-call requirement. RNs assist with clinical oversight and supervision of staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has implemented an electronic quality risk management plan from an external consultant. 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 two to three monthly full staff meetings.  The service has in place a range of policies and procedures to support service delivery that includes hospital level and policies appropriate to the specific needs of younger disabled people. 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 was an annual resident/relative satisfaction survey completed in January 2021 using Survey Monkey. Results from this were provided to staff in meetings.  Resident meetings are held bi-monthly with an elected resident representative submitting a report to the monthly board meeting. All residents interviewed stated they are aware of the resident representative and how to raise their concerns and suggestions.  There are monthly healthcare assistants’ meetings, monthly clinical meetings and two to three monthly full staff meetings. Meeting minutes evidenced discussion around quality data including (but not limited to) complaints, compliments, health and safety, accident/incident, infection control, internal audit and survey results. Trends are identified and analysed for areas of improvement. Meeting minutes documented in-depth discussion linked to audits, incidents, restraint and infection control each month. Individual resident needs are discussed at meetings where issues have been raised. Healthcare assistants confirmed on interview they were kept informed on quality data including corrective actions and quality initiatives.  Internal audits are completed as scheduled. Corrective action plans are completed for any corrective actions required. The quality coordinator signs off completed corrective actions. Internal audits are discussed along with corrective actions as needed during staff and RN/clinical meetings.  The health and safety representative role is shared between the maintenance manager and quality coordinator, both of whom have recently completed level two training. The health and safety representatives provide documented reports and attend the monthly quality/management meeting. Relevant information and graph data is disseminated at staff meetings. As part of the staff meetings, trends from adverse events and infections are discussed. All staff have access to the online electronic quality reports including the hazard register. A hard copy of the hazard register is available in the nurses’ station. A review of the hazard register indicated that there is resolution of issues identified. Orientation and annual training programmes ensure all staff are familiar withal aspects of health and safety and emergency management.  Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. Health and safety information is displayed on the staff noticeboard. |
| 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 | As part of risk management and the health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to all facility meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.  Twelve incident forms were reviewed from March 2021 on the online system. All incident forms identified timely RN assessment of the resident and corrective actions or recommendations that had been completed and signed off by the clinical manager/acting CEO. Neurological observations have been completed for unwitnessed falls and any known head injury. The caregivers interviewed could discuss the incident reporting process, they also described the discussion of incidents at monthly meetings.  The clinical manager could describe situations that would require reporting to relevant authorities. The service has reported five section 31 notifications (two pressure injuries, two trespasses and one other). |
| 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 resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Seven staff files were reviewed (two RNs, one quality coordinator and four healthcare assistants). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  Registered nurses have access to external training that includes clinical education relevant to medical conditions. In-service education delivered by internal and external educators included (but not limited to); end of life/palliative care, caring for younger people with a disability, pressure injury prevention and management, wound care, and pain management. Additional training related to new policies, incidents, infection control and current issues occur at staff meetings.  There is a robust and comprehensive in-service education programme has been developed by the learning and development clinical manager/acting CEO. Careerforce qualifications are encouraged. There are 12 HCAs with level 4 and four with level 3. Others are actively working on completing. The training programme for 2020 was fully implemented and 2021 is being implemented as scheduled. 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. Nine of the ten registered nurses including the clinical manager/acting CEO, and learning and development manager, are interRAI competent. Staff complete competencies relevant to their roles. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented policy that determines staffing levels and skill mixes for safe service delivery. A review of the staff ratio and mix identified the roster provides sufficient and appropriate coverage for the effective delivery of care and support.  A senior nursing team is in place, there is a full-time clinical manager/acting CEO, a learning and development manager and an experienced EN who work from Monday to Friday. The current registered nurse team is very stable and experienced. 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.  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 14 rest home residents in total scattered throughout the seven wings. Of the 14 rest home residents, two are in rooms upstairs in the Rata wing (both residents are mobile and can manage the stairs independently, there is also a lift available should the residents prefer to utilise it).  There are two RNs on the AM and the PM shift (both full shifts) and one RN at night.  There are six healthcare assistants on the AM (three long and three short) and five on the PM shift (three long and two short shifts) and two healthcare assistants on the night shift. Healthcare assistants interviewed were happy with staffing levels. One of the HCAs on the morning shift covers the rest home residents in the upstairs Rata wing. There are two- three activities staff rostered each weekday (one long and one short shift). Care staff supported by volunteers implement the activities programme in the weekends.  There are dedicated laundry and cleaning staff. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are paper-based and electronic resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents’ individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation. |
| 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’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Residents are assessed prior to entry to the service by the needs assessment (NASC) team or other appropriate agency, and an initial assessment is completed on admission. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families regarding palliative care.  All admission agreements reviewed aligned with the contractual requirements. Exclusions from the service are included in the admission agreement. A total of seven signed admission agreements were sighted. Family members interviewed confirmed the staff had fully explained services to them on entry to the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer/discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge documentation is integrated in the resident file and care plan. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The controlled drug register evidenced a process of reconciliation of controlled drug stock. All medicines are stored securely. Registered nurses and healthcare assistants complete annual medication competencies and medication education. The medication room is at the nurse’s station. RNs complete the administration of medication; there are three lockable medication trolleys. A recent medication management internal audit was completed with no corrective actions or medication errors/incidents.  The RNs are responsible for medication reconciliation against the blister packs for regular and ‘as required’ medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. There are procedures in place to facilitate safe self-administration of medication for three residents (inhalers). There are no medication standing orders in use. All eye drops were dated on opening.  Fourteen electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP has 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. Nutritional supplements are documented and administered from the electronic medication chart. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Rannerdale Village are prepared and cooked on site by a contracted meal service provider. The service changed contracted meal service providers in June 2020. The kitchen has a servery opening out to a rest home dining area. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated.  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. A cleaning schedule is maintained. All food preferences are met. Fridge and freezer temperatures are taken, calibrated regularly and recorded daily on an electronic management system. A current food control plan has been verified in December 2020.  The chef manager (regional manager) is supported by a chef and catering assistant and kitchenhands. All staff have completed food safety education. Residents’ nutritional assessment including likes and dislikes are identified and provided to the kitchen on admission. The chef manager interviewed, is knowledgeable regarding specific residents needs including those with diabetes, unintentional weight loss (or gain) and recent dietitian input.  Food is transported in hotboxes to a bain marie to two other serving areas. On the day of the audit staff were observed to assist with the lunch meal in the hospital dining room. Dining rooms have enough space to move safely during meal times. Snacks are available and special cutlery is available when needed. Residents are encouraged to comment on the food service in the book provided in the dining rooms and through the resident meetings. A food service internal audit was recently completed with no corrective actions required. The residents and family interviewed expressed satisfaction with the food provided. |
| 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 | The RNs complete an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and every six months. Resident needs, support and goals are identified through the ongoing assessment process and form the basis of the long-term care plan. There were regular pain assessments evident for a resident with complex co-morbidities. Residents interviewed confirmed their preferences and choices are accommodated during their care journey. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Seven residents’ long-term care plans were reviewed. The interRAI assessment triggers and scores forms the basis of the long-term care plan. Care interventions are detailed to a level that supports their individual needs and goals. Assessment outcomes were included in the long-term care plans reviewed. The long-term care plan identifies interventions that cover a set of goals including managing medical needs/risks.  Alerts on the resident’s profile page identify current and acute needs such as (but not limited to); current infection, wound or falls risk. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.  All files include a 24-hour activity plan and recreational plan with documented individual daily routine. For those residents that present with challenging behaviours; triggers, and activities to distract and de-escalate behaviours are documented with associated risks. There was evidence of allied health care professionals involved in the care of residents including physiotherapist, podiatrist, dietitian and an occupational therapist. One resident (YPD) had a specific plan for unintentional weight gain. The contracted physiotherapist reviews residents for mobility support and seating requirements. The GP, dietitian and allied health professional progress notes were evident in the residents’ files sampled. Any change in care required is documented and verbally passed on to relevant staff. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observation and interview with the RNs verified that care provided to the residents is consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including sensor mats, hoists (standing and full), transfer belts, lap belts, pressure relieving mattresses and cushions were available for use.  Continence, wound care products and PPE were in stock for use. Staff received annual education in continence management and wound care management.  The wound register was reviewed and current; an updated wound care policy including PI management, and management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place for fourteen residents (across services). There was one resident with three recorded minor wounds due to lower leg vascular anomalies and one pressure injury, ten minor skin tears, three lower leg ulcers recorded in the wound register.  Incidence of skin tears are mostly related to the high usage of power chairs within the facility; risks are managed accordingly. Wound assessments, plans and reviews are current and completed. Interventions were undertaken in the stated timeframes. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed. Monitoring records for (but not limited to) weight, catheter changes, food and fluids, blood sugars, behaviours and routine observations including neurological observations after unwitnessed falls demonstrated that appropriate care delivering is occurring. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | The activities assistant works 40 hours a week supported by two part time activities assistants (one of whom also works as rehabilitation therapist). The activities assistant is working towards her diversional therapist qualification and oversees the activity team, documentation and spends one-on-one time with residents. All activities assistants work Monday to Friday. One activities assistant is also the rehabilitation assistant and assists with mobility support, exercise plans and works alongside the physiotherapist. There are three regular volunteers on Saturdays that assist with canine friends and circle bowls.  There are seven active volunteers assisting with various activities throughout the month including walking groups and to accompany residents to community involvement activities (salvation army, pub, shopping). The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme.  The activities staff at Rannerdale Village 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 noticeboards. Group activities are voluntary and developed by the activities staff in consultation with the clinical manager/acting CEO, physiotherapist and rehabilitation assistant (employed). Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities and is age appropriate. A number of clubs and groups have been initiated by residents including the younger people. Activities are purposeful and focussed to decrease depression, challenging behaviour and mindfulness (laughter yoga, memory group, brain gym, wellbeing group, Rannerdale Village choir). There is evidence of pastoral care though the provision of church services including Māori church once a month and regular prayer groups.  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 and art group. Younger people are supported to access community groups/events of their interest including but not limited to RSA and community men ‘shed. Social interaction is further promoted through weekly community groups visits to Rannerdale Village.  The activity staff 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 two vans which are used for resident outings and trips into the community.  Residents and relatives interviewed spoke positively of the activity programme with feedback and suggestions for activities made in resident meetings.  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. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review with the clinical manager, RN, healthcare assistants and DT. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing. |
| 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 | Rannerdale Village facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, occupational therapist, ear health nurse, physiotherapy and the podiatrist. |
| 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 | There are implemented policies in place to guide staff in waste management. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly in the original containers, and safety data sheets and product information are readily available to staff. Gloves, aprons and visors are available, and staff were observed wearing personal protective clothing while carrying out their duties. RNs and healthcare assistants interviewed confirmed enough pandemic supplies are available. Staff have completed chemical safety training and staff could describe the pandemic/outbreak plan of the facility.  There are implemented policies in place to guide staff in waste management. |
| 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. 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.  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 are provided. The facility has a designated resident smoking area away from the buildings and complies with the recent legislative changes to include the requirements of vaping.  Healthcare assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Resident rooms have handwashing facilities and are single occupancy. There are sufficient communal toilet/showers to meet the needs of the residents. All communal toilets and showers have appropriate signage and locks on the doors. Fittings, fixtures and flooring is appropriate. Communal staff and visitor toilets are identifiable and equipped with locks, flowing soap and paper towels. All rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents’ rooms are personalised. There are an adequate number of toilet and showering facilities. Privacy locks are in place. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares. |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided in a safe manner and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is one large lounge with seating arranged to allow residents to mobilise freely and a conservatory adjacent to this. There are smaller lounges and private areas for computer access. There is also a fully equipped gym available for safe supervised exercises.  Dining areas are spacious to accommodate safe mobility for staff, residents and those residents in power chairs. All areas are easily accessible for the residents. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. Manufacturer’s data safety sheets 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 employed by an external contractor (same as the food service). 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/pandemic procedures and manual in place. There is an approved fire evacuation scheme. Fire safety training has been provided. Fire evacuation drills have been conducted six-monthly with the last fire drill occurring on 29 January 2021. There is a staff member with a current first aid certificate on duty 24/7.  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 BBQs and four gas bottles) are available. There is a generator available on request if there is a power failure. Emergency lighting is available for back-up. 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.  There is a list of staff and community numbers for emergency contact and an updated evacuation resident list including mobility status of each resident. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. All resident rooms and the communal areas have external windows that open, allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Rannerdale Village 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 infection control coordinator is the clinical manager/acting CEO (a registered nurse) who commenced the role in July 2020. The infection control team includes the registered nursing team. The infection control coordinator oversees infection control for the facility and reports to quality/management, clinical and staff meetings.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. Staff are kept informed of Covid related risks and responses. The service has a documented pandemic management plan. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The RN infection control coordinator has completed online IC training and is booked to attend the local DHB IC training next month. The infection control committee is part of the staff meetings as well as the RN meetings. Infection control is a standing agenda item and both meetings document discussion of all infections.  The infection control coordinator has access to GPs, local laboratory, the infection control nurse specialist and public health departments at the local DHB for advice. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and are reviewed regularly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed for staff.  Resident education is expected to occur as part of providing daily cares as appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place and appropriate to the complexity of service provided. Infection control data is discussed at both the staff and RN meetings. Trends are identified, and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit, there were eight residents with enablers (one resident used three different enablers) and one resident with emergency restraint. Seven enablers were lap belts, two bed rails and two chair tables. Emergency restraint involves disabling the electric wheelchair to prevent injury to other residents. Two resident files reviewed; one for restraint and one for enabler use, both documented an assessment, consent and regular reviews. Restraint and challenging behaviour education are included in the training programme. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The clinical manager/registered nurse is the restraint coordinator with a defined job description. Restraint is discussed in detail at monthly clinical meetings and is an agenda item at quality management and staff meetings. A comprehensive six-monthly review is completed. Care staff receive education on safe restraint use at orientation and ongoing. There is ongoing education including challenging behaviours. Staff complete restraint competencies. Staff carry out and record restraint monitoring, including care delivered during the restraint period. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership, with the resident and their family/whānau undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form was completed for the one resident requiring restraint and one of the seven enabler files reviewed. Assessments identify the specific interventions or strategies to try (as appropriate) before implementing restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation are included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use, risks and cares to be carried out during the restraint episode are included in the care plan. There is an up-to-date restraint register. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluations occur three-monthly in conjunction with medical reviews as part of the ongoing review for residents on the restraint register, and as part of their care plan review. Families and the GP are included as part of this review where possible. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraint usage is monitored regularly while in use. The review of restraint use is discussed at the monthly staff and monthly RN meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed. Individual enabler and restraint use are also reviewed during three monthly GP reviews and six-monthly care plan evaluations. |

# Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The activities team have embedded a resident focused activity programme that is inclusive of all residents across the service. In response to resident-initiated activities and involvement in many aspects of the service, the resident’s satisfaction with the activities programme is evidenced by attendance and resident group involvement. Activities are culturally appropriate and meet the spiritual care needs of the residents. Residents are a part of all decision-making processes and this is evident in the resident meetings and resident attendance numbers.  Rannerdale Village developed quality initiatives aiming to increase the sense of belonging to improve psychological well-being of all their residents.  The project was initiated as a result of resident and family/whānau feedback. Family/whānau often commented they did not have a current photo of their loved one and residents not having whānau to celebrate special occasions with (e.g., Valentine’s day and older persons day).  Three projects were reviewed and discussed on site:  The projects aimed to ensure: a) there are current photos available for residents’ families; b) residents that do not have close relationships with relatives feel included during special events, c) establishment of community links with the local school and d) to involve staff in a non-medicalised approach to health and wellbeing of residents.  1. A space in the facility was decorated with props and Christmas decorations and called “Ballantynes Christmas Corner”. Personalised photos were taken of each resident. Family/whānau were included to create an opportunity for family photos. Staff and volunteers were allocated tasks - photographer, card making and postage. Registered nurses and healthcare assistants were involved to assist to write messages. Cards were sent to family/whānau and were also used as decorations for walls and doors.  2. All staff wrote messages of kindness to the residents on special event days. Messages were individualised for each resident and appropriate for their age.  3. Middleton school pupils who passed the facility gates every day were reluctant to engage positively with residents and had developed a fear-based attitude towards residents. The service staff engaged closely with the school children, parents and teachers to develop a number of shared activities. Visits between the school and Rannerdale occur on a weekly basis with many children forming continuity and mutually beneficial relationships with the residents. Residents and children now greet at the service gates and greet each other daily.  Staff interviewed expressed their excitement around their involvement with the activities and that it brought a sense of positivity to the environment. Residents expressed that they felt valued as a result of the initiatives and families were grateful for the opportunities created. The clinical manager/acting CEO and quality coordinator interviewed confirmed there was an improvement in overall wellbeing of the residents. | Rannerdale Village has implemented an activities programme that is meaningful, age appropriate and varied for the residents. The programme allows residents to maintain strengths and skills, maintain connections with the community and create a sense of belonging though events and activities that they would normally not be able to access. Through various initiatives inclusiveness, participation and a sense of belonging of residents across the service has improved. Furthermore, quality data evidenced incidents of challenging behaviour decreased since early July 2020. The initiatives had such a positive outcome for residents and staff alike and require minimal resources and skills and will continue to be part of Rannerdale Villages daily practices and activities programme. The depth and breadth of activities seen in the Rannerdale Village activities programme exceeds what is expected for the full attainment of this criteria. |

End of the report.